SEE FOLLOWING NOTE

VOIR NOTE CI-APRÈS

PARTS OF THE ORIGINAL DOCUMENT ARE OF POOR REPRODUCTIVE QUALITY.

MICROMEDIA LIMITED HAS ATTEMPTED TO PRODUCE THE BEST POSSIBLE COPY.

CERTAINES PARTIES DU DOCUMENT ORIGINAL SONT DE PIÈTRE QUALITÈ DE REPRODUCTION.

MICROMEDIA LTEE A ESSAYEE DE PROCURER LE MEILLEUR EXEMPLAIRE POSSIBLE.

91-03563/

Investing in Children

New Directions in Child Treatment and Child and Family Intervention

---

A Consultation Paper

Ontario

Deputy Minister
Sous-ministre

Ministry of
Community and
Social Services

Ministère des
Services sociaux
et communautaires

Hepburn Block
Queen's Park
Toronto, Ontario
M7A 1E9

416/965-2344

Édifice Hepburn
Queen's Park
Toronto (Ontario
M7A 1E9

January 1988

Dear Friends:

It is with pleasure that I present you with a copy of "Investing in Children: New Directions in Child Treatment and Child and Family Intervention." This consultation paper proposes directions for the development of a number of areas in children's services. It is part of the overall strategy of facilitating a more flexible, community-based service system for children articulated in the ministry's Corporate Plan.

It is our hope that the programs and plans contained herein will be used in local consultation meetings to build a consensus on the role of Child Treatment and Child and Family Intervention services as part of the CFSA flexible services system. The Children's Services Division heralded dramatic change between 1977 and 1982. Now, as the children's services area is beginning to stabilize, the time is ripe for a careful reexamination of priorities in program development.

The document proposes a series of directions for three levels: improving responsiveness of services; setting specific target groups; and promoting area planning. Some of the directions have thematic familiarity, in part because promoting higher standards of client and community responsiveness is a continuing thrust in the children's area as in other program areas of the ministry.

A new approach is the promotion of formal linkages between CFSA-based services and other publicly funded services or voluntary, self-help and natural helping networks. These linkages should result in more flexible and improved local service networks. In addition, the focus on three particular population groups represents a clear indication of priorities for the development of new services and provides an opportunity to influence the structure of the existing service network. Finally, a focus on area level planning is intended to involve the major stakeholders in priority setting and planning, as well as provide a forum for local problem solving and linkage building.

I invite you to join with children's services colleagues, parent groups and planners in your community in the next few months to get together and comment on the ideas presented in the document. The directions and strategies identified do not represent a final policy. With your input through the consultation process we expect to produce a concise policy statement. This policy statement will be issued following the consultation. In the interim, these directions and strategies can be acted upon as a planning guide to promote the development of the network with the funding increments that followed the spring 1987 Throne Speech.

We look forward to participating with you at the local level through the ministry's area offices and various provincial organizations. The voluntary efforts and dedication of the children's services community are essential in building a future of opportunity for troubled children in Ontario. We invite your continued help and commitment to build this future.

Sincerely,

Peter H. Barnes
Deputy Minister

ACKNOWLEDGEMENT

Thanks are due to a number of people who have contributed to the ideas developed in this discussion paper.

The views and divergent orientations of the key informants identified in Appendix A were extremely helpful in informing the perspectives that follow. Dr. Dan Offord and Michael Boyle of McMaster University offered lively commentary on uses of the Ontario Child Health Study data. Dr. Alex Richman of Dalhousie University provided helpful discussion on the limits of psychiatric epidemiological data. Dr. Paddy Colfer of the Children's Services Branch and Gail Gentleman offered invaluable assistance in developing the data presented alongside the text. Thanks are also due to Andria Hourwich for editorial assistance.

The following individuals offered generously of their time in discussion of topical issues in the treatment and care of children. While no individual in this reference group is responsible for any shortcomings in the development strategy presented here, each person offered a range of helpful comments in the development of the document, and their collective guidance was invaluable.

Dr. Naomi Rae-Grant
Children's Hospital of Western Ontario
London

Sheila Weinstock
Executive Director
Ontario Association of Children's
Mental Health Centres
Toronto

Claire Braseliten
Executive Director
Ontario Association of Children's
and Youth Institutions (ONTCHILD)
Toronto

Peter Murchison
Prevention Co-ordinator
Community Services
Ministry of Community
and Social Services
Queen's Park, Toronto

John Liston
Executive Director
Child and Family Services
of London-Middlesex
London

Dr. Jim Armstrong
Director of Administration and
Evaluation
George Hull Centre
Etobicoke

Dr. Christel Woodward
Professor of Epidemiology and
Biostatistics
McMaster University
Hamilton

Yale Drazin
Director
Mental Health Planning
Ministry of Health
Queen's Park, Toronto

Agnes Samler
Executive Director
Thistletown Regional Centre
Rexdale

Erwin Pasternack
Education Officer
Special Education and Provincial
Schools Branch
Ministry of Education
Queen's Park, Toronto

Project Leader: Terry Sullivan, Senior Policy Analyst
Children's Services Branch
Ministry of Community and Social Services
Queen's Park, Toronto

EXECUTIVE SUMMARY

The recent proclamation of the Child and Family Services Act has shifted planning and funding for children's services in Ontario from an agency base to a services or program basis. This provides an opportunity to rethink the future development of child treatment and child and family intervention services. The Ministry of Community and Social Services intends this consultation paper to provide a statement of provincial commitment and priority, stimulate consensus building on the role of child treatment and child and family intervention services, and influence the structure of new services in order to meet the needs of disturbed children and families in the most effective manner.

The main resources for serving disturbed children are described in the context of a range of groups and organizations that have significant roles to play in serving disturbed children and their families.

Prevalence of childhood psychiatric disorder and utilization of social and mental health services are examined using the Ontario Child Health Study and other data sources. Dedicated treatment and intervention services appear to reach a small portion of those children who have childhood psychiatric disorders. This would seem to be a function of a number of factors. Childhood psychiatric disorders do not all necessarily cause impairment in the child's functioning. Where they do cause impairment, the impairment is not equivalent across all psychiatric disorders nor is it equivalent over time. Parental recognition and motivation strongly influence who uses services. Service providers also exercise different admission practices and criteria, and there is a range of important helping agents and actors outside of the dedicated children's services area who provide service to children and families. Specialized treatment and intervention services cannot realistically provide services to all children and families in distress. Program development priorities are needed.

These priorities can then be used to guide local and area level planning. An idealized spectrum of treatment and intervention services is provided as the basis for local planning. Both MCSS and non-MCSS resources for disturbed children should be included when developing the local spectrum of services.

A series of directions for investment in and development of treatment and intervention resources is then proposed, intended to yield the best outcomes, and to link these resources most effectively with natural, voluntary and other children's services organizations. Seven directions are proposed, together with concrete strategies designed to provide discrete population and program emphases. These directions also reinforce the empowerment of clients and local communities in shaping services. The ordering of these directions does not represent an order of priority, but a description of levels of application of the directions. These directions are the following:

- Directions at the level of children and their families:

  Direction 1: Responsiveness of service.

  Direction 2: Continuity of service.

- Directions at the level of program design and target populations:

  Direction 3: Primary prevention with "at risk" populations.

Direction 4: Early intervention with the youngest identifiable disturbed children.

Direction 5: Co-ordinated and responsive services for the seriously and chronically disturbed.

- Directions at the level of <u>local planning</u>:

Direction 6. Enhanced area planning.

Direction 7: Structuring a spectrum of services.

Consultation on the paper will be carried out during the winter and spring of 1988 and followed by a Ministry review of the response, leading to a more precise policy position during the latter part of 1988-89.

"Adults always say that the young are the future, but they are also the present!"

18-year-old student quoted in Bibby, R.W. and Posterski, D.C. The Emerging Generation: An Inside Look at Canada's Teenagers. Toronto: Irwin, 1985, p. 154.

CONTENTS

		Page
Acknowledgement		i
Executive Summary		iii
1. **Background**		1
	Purpose	1
	Value Orientation	2
	Flexible Services and the CFSA	4
	Reasons for a Focus on Treatment and Intervention	6
	Scope and Format	8
	Summary	12
	Notes	12
2. **The Service Environment**		17
	The Current Resource Base	17
	Emerging Client and Service Trends	22
	Summary and Directions	28
	Notes	29
3. **The Need For Specialized Services**		33
	Identifying Who Needs Service	33
	Primary, Secondary and Tertiary Intervention	42
	Summary and Directions	47
	Notes	48
4. **Planning To Weave Local Services Together**		53
	Area-Level Planning	53
	Evaluation of Program Design	57
	Summary and Directions	59
	Notes	59
5. **Development Strategies**		63
	Direction 1: Responsiveness	64
	Direction 2: Continuity of Service	68
	Direction 3: Primary Prevention with "At Risk" Populations	70
	Direction 4: Detection and Early Intervention	71
	Direction 5: Responsive Services for the Seriously and Chronically Disturbed	72
	Direction 6: Enhanced Area Planning	74
	Direction 7: Structuring a Spectrum of Services	76
	Summary	79
	Notes	80
Appendices		
A. Key Individuals and Organizations Consulted		
B. Goals of the Original Children's Services Division		
C. Child and Family Services Act Service Definitions		
D. Key Point History of Services for Disturbed Children in Ontario		

E. The Ministry of Health's Role in Treatment Services for Disturbed Children

F. Services Provided by the Ministry of Education for Children with Special Needs and Exceptionalities

G. Miscellaneous Background Data

H. Sample Memoranda of Agreement

I. Ranking of Ontario Divisions on Social Indicators

2M/8/8[illegible] Repr.
ISBN O-[illegible]7729-3462-2
© Queen's Printer for Ontario, 1988
Photo Credits: Miller Comstock

"The child is the asset of the State, and all conditions should be arranged as far as possible to get the best results from that child...as perfect a thing as can be produced; something to be proud of; something with stability and quality, that can be used for the purpose of development and advancement..."

From an address on child welfare by Dr. Isabel Arthur to the 1917 meeting of the British Columbia Board of Health quoted in chapter by N. Lewis in P.T. Rooke and R.L. Schnell (eds.). Studies in Childhood History: A Canadian Perspective. Calgary: Detselig Enterprises Ltd., 1982, p. 135.

1. BACKGROUND

In a world of increasing complexity, an easy path for the child to adulthood is less assured than ever. Meeting the needs of the most troubled among our children and their families is a pressing concern of this Ministry as both a funder and a provider of child treatment and intervention services.

The pages that follow explain:

- the purpose of this discussion paper
- the values attached by the Ministry to child and family services
- the significance for child and family services of the flexible services concept
- the reasons for the focus in this paper on child treatment and child and family intervention services
- the scope and format of this paper.

Purpose

The purpose of this document is to stimulate the development and delivery of services to children and the families of children with social, emotional, behavioural, and psychiatric problems. The pages that follow provide perspective on the environment in which these services operate, and set out a series of strategic directions designed to promote the development of the services. These directions are oriented towards developing services at three levels:

1. the level of children and their families

2. the level of program design and target populations

3. the level of local planning for services.

It is the Ministry's hope that this document will be used as a vehicle for discussion by child and family agencies, professional groups, consumers, and local planning groups. It is a statement of provincial direction, commitment and priority for continued development of "state of the art" quality services

for disturbed children and their families. In addition, the document is intended to assist in progress towards two broad goals:

1. to develop a regional and provincial consensus on the role of child treatment and child and family intervention services within the Child and Family Services Act

2. to influence the structure of the existing network of services as well as the development of new services to respond most effectively to the needs of children and families.

Consultation on the paper will be carried out during the winter and spring of 1988 and followed by a Ministry review of the responses, leading to a more precise policy position during the latter part of the 1988-89 fiscal year.

Value Orientation

While Isabel Arthur's comment on investing in children may seem a little short on warmth and nurturance, it underlines a certain reality, and is still timely. Even from a purely economic perspective, moderate investments of human and non-human capital in children produce appreciation in human and non-human capital later on.

In its overall strategic plan, set forth in 1986,[1] the Ministry of Community and Social Services (MCSS) identified a series of objectives and strategies to support individuals and families. Included was a specific strategy outlined to "develop policies and mechanisms to facilitate a more flexible, community based service system for children".

In essence, this strategy reflects the values established by the Ministry in 1977 with the consolidation of children's services. The goals established for the original Children's Services Division within MCSS were presented in Children's Services: Past, Present and Future. The ambitious goals for the development of the children's services system at that time are reproduced in Appendix B. It is easy to see the continuity between these goals and the principles eventually embodied in legislation in the Child and Family Services Act (CFSA), which are used as the value base for the development of all

services under the Act. These principles are contained in Sections 1 and 2 of the CFSA, which state that:

"1. The purposes of this Act are,

(a) as a paramount objective, to promote the best interests, protection and well-being of children;

(b) to recognize that while parents often need help in caring for their children, that help should give support to the autonomy and integrity of the family unit and, wherever possible, be provided on the basis of mutual consent;

(c) to recognize that the least restrictive or disruptive course of action that is available and is appropriate in a particular case to help a child or family should be followed;

(d) to recognize that children's services should be provided in a manner that,

(i) respects children's needs for continuity of care and for stable family relationships, and

(ii) takes into account physical and mental developmental differences among children;

(e) to recognize that, wherever possible, services to children and their families should be provided in a manner that respects cultural, religious and regional differences; and

(f) to recognize that Indian and native people should be entitled to provide, wherever possible, their own child and family services, and that all services to Indian and native children and families should be provided in a manner that recognizes their culture, heritage and traditions and the concept of the extended family.

"2. (1) Service providers shall, where appropriate, make services to children and their families available in the French language.

(2) Service providers shall ensure,

(a) that children and their parents have an opportunity where appropriate to be heard and represented when decisions affecting their interests are made and to be heard when they have concerns about the services they are receiving; and

(b) that decisions affecting the interests and rights of children and their parents are made according to clear, consistent criteria and are subject to procedural safeguards."

Flexible Services and the CFSA

The CFSA was proclaimed in late 1985, and is currently in force except for most of Part VI and for Part VIII. These Parts of the Act will be phased in in the near future, once amendments and implementation plans are finalized. Thus we are in a time of transition and consolidation, adapting to the demands of the new piece of legislation. As we move towards full implementation of this Act, a reconsideration of the early goals and intentions of the legislation may recapture and hearten our imagination along the way. In the spirit of the consolidation of children's services, the CFSA was designed to integrate principles and services for children with special needs under a single piece of legislation. This has been and continues to be an ambitious objective, but one to which the Ontario Government and the Children's Services Branch remain steadfastly committed.

The CFSA introduced the concept of "flexible service". The CFSA recognizes a range of services for children, originally grouped broadly into five categories. In addition, a sixth category of services is being introduced with a number of other amendments to the CFSA. These six categories comprise:

1. child development service
2. child treatment service
3. child welfare service
4. community support service
5. young offenders service
6. child and family intervention service.

These service categories are further defined in Appendix C. The categories are not intended to be precise boundary devices to separate services for abused children from mental health services or from probation services, etc. They are conceptual tools for flexible program planning and funding.

The CFSA flexible service provisions are designed to **enable** flexible development and evolution of services in line with local need. The flexible service mechanism allows multiple service categories within one agency, which prior to the CFSA could not be easily achieved. It provides the potential to develop services around individual and local need rather than a clinical label, a social problem, an agency, or a legislative boundary. Until recently, the development of services was hampered by the presence of multiple, and sometimes contradictory, pieces of legislation governing distinct agencies. As is well known, the children most in need have a habit of crossing legislative, service and agency boundaries.[2] Many of our most disturbed and complex clients use more than one service stream (e.g., child welfare, child treatment, young offenders). The flexible services concept represents significant progress towards building services around children. It is a step towards continuity and integration of service, and away from legislative and funding boundaries that separate services to children. Flexible services, combined with local planning, provide the potential for the first time to define and develop at the community level a range of services for children with special needs that reflects the needs of a particular community.

It would by no means be accurate, however, to claim that the service streams are, or ought to be, generic. Certainly, some functions are generic, such as assessment, shelter, care, and direction, but groups of children will continue to have distinct needs for specialty services. Moreover, state of the art practice and wisdom in child protection, probation, treatment, prevention or child development services change and develop on overlapping but distinct timetables. It is in part a concern with state of the art practice and wisdom that has driven the development of this document. The flexible services mechanism for planning and funding is meant to reduce structural barriers to service, while enabling the elaboration and evolution of well-linked specialty services in response to changing local need and current views of state of the art practice.

Reasons for a Focus on Treatment and Intervention

Given the need to break away from service streams and legislative boundaries, what is the wisdom of a discussion of child treatment and child and family intervention services* at this time? It would appear to be somewhat contradictory to discuss breaking down boundaries between service streams while simultaneously discussing treatment and intervention services as a distinct service stream. It is the Ministry's view, however, that a broad discussion across the service community with a focus on this specific service stream is essential at this time.

While the mechanism to plan and fund flexibly now exists within the children's services funded under CFSA, flexible services in themselves do not represent any blueprint for development. Treatment and intervention services constitute a complex pool of children's services and comprise a large portion of MCSS child and family services. Yet in the ten years since the consolidation of children's services, they have never been the subject of broad public discussion and priority setting. In the spring 1987 throne speech, the Ontario Government announced that "special emphasis will be placed on the province-wide delivery of mental health services and the community-based network of children's mental health services will be expanded to provide children with support in their own homes and community". Given the announced expansion, this discussion and priority setting are undeniably timely.

In fact, it has been about 20 years since the white paper by Matthew Dymond[3] led to the development of "regional centres" in key areas of the province. Although the regional centre notion in its original form has disappeared, regions within MCSS recognize the need for regional specialty programs, which may be located in a number of specialty services and agencies, not just one.

Historically, treatment and intervention services in Ontario were not enshrined in legislation as essential or mandatory, and thus were not

---

* In the interest of brevity, this paper will refer to these services in short form as "treatment and intervention services".

subjected to sweeping reform like young offenders or child welfare services. (See Appendix D for a brief history of publicly funded treatment and intervention services for children in Ontario.) In its early years, this sector developed overlapping activities with those of child protection, young offenders and services for the developmentally handicapped. It developed a strong momentum of its own in the postwar years as the fashion shifted from a child welfare and correctional model for dealing with disturbed children to one with increasing emphasis on psychological factors and treatment methodology.

Treatment and intervention services in Ontario have developed in part around the old model of pivotal "regional centres". The growth of these services in the past two decades or so has proceeded, in the absence of an articulated development plan, in response to local need, as a function of local and individual initiative and using diverse clinical models. Most of this growth occurred in an atmosphere of economic prosperity. As a result, treatment and intervention services in Ontario are provided by a large number of organizations funded by the Province, ranging from small to very large, and with different basic services.

It is particularly because of the continuous redefinition by the research and service communities of essential and effective programming that the treatment and intervention sector begs for some common direction. Moreover, planning is essential if this patchwork of services is to be transformed into a network of services. Planning for the development of treatment and intervention services will require both continuing awareness of the effects of the 1982 recession and a cautious optimism for the future. It must blend the visionary optimism, imagination and innovation of economically prosperous times with the rational, systemic and critical priority setting that accompanies a time of restraint.

It is also simply impossible to have an informed and useful discussion of state of the art practices across all service categories simultaneously, beyond the broad principles of the CFSA referred to earlier. The Ministry has implicitly recognized this difficulty, undertaking separate development plans in the several children's services areas within the context of an overall strategic plan. In the area of developmental services, for example, the Multi-Year Plan is beginning to unfold with profound implications for children, adults and

their families over the next few years. In addition, the Disabled Services Branch is currently developing a document on services for the "dual-diagnosis" population, those individuals who are both developmentally handicapped and emotionally or mentally disturbed. Child welfare services are to be reviewed. In the case of young offenders, the Ministry is developing a position on the use of secure custody that will be available in the near future. There is also much activity in the area of prevention and community support services that cuts across a range of ages and populations. Some discussion of prevention will necessarily be part of and continuous with the discussion of treatment and intervention services.

Finally, the CFSA has shifted the legislative base for this large pool of services. It would seem useful and timely to draw up a development agenda for this service sector and its links with other CFSA services and broader community efforts to reduce or ameliorate child and family problems. Figure 1, on page 9, depicts in idealized fashion the overlapping service streams within the CFSA. It also schematically depicts the overlap of services between ministries and privately funded, self-help and voluntary groups and organizations. Setting directions for the development of treatment and intervention services will require strategies for linkage not only to other child and family services and organizations funded by MCSS under the CFSA and Day Nurseries Act, but also to services funded by other ministries and by other self-help and voluntary groups serving disturbed children and their families. While the focus of this paper is on treatment and intervention services, the directions it offers may also be applicable to the other service categories of the CFSA and beyond.

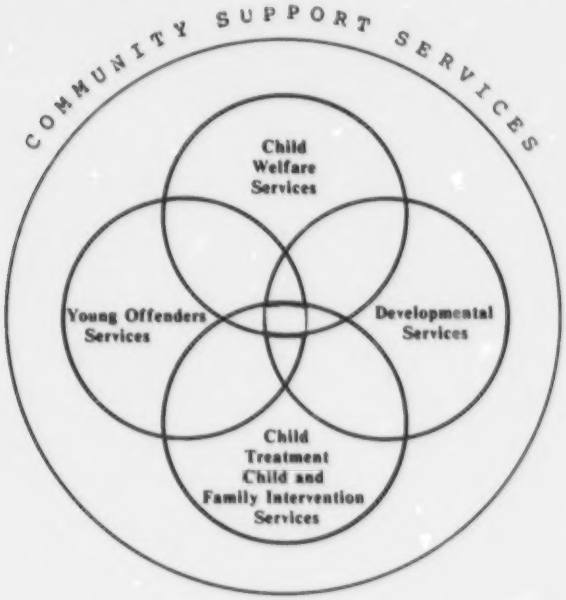
Scope and Format

This paper offers some fresh thoughts on how some old problems may be viewed, approached, and struggled with anew. It represents the commitment of the Children's Services Branch of MCSS to fulfill its provincial leadership role in the development of community services for disturbed children.

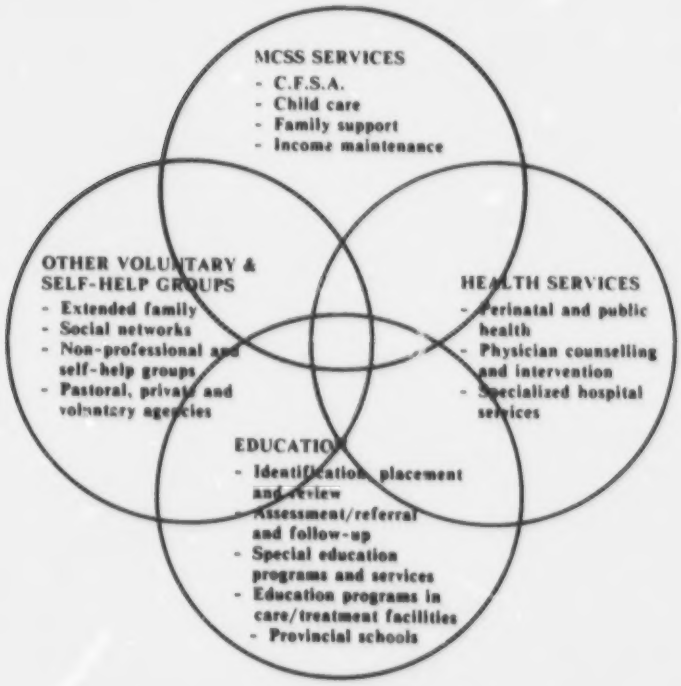
Table 1, on page 10, gives a schematic impression of the range of other actors involved in finding, assessing, and serving children or families, or referring them for treatment and intervention. It shows plainly that MCSS has no monopoly on services for disturbed children. At the local level, there

Figure 1

CFSA-BASED AND COMPLETE COMMUNITY SERVICE SYSTEM FOR CHILDREN AND FAMILIES WITH SPECIAL NEEDS



CFSA Flexible Service System For Children and Families With Special Needs



Complete Community Service and Support System for Children and Families with Special Needs

Table 1

CURRENT POPULATION SCREENING SYSTEM FOR CHILDREN AND FAMILIES WITH SPECIAL NEEDS

Factors influencing impairment & use of service	Client populations	Casefinding	Assessment & basic intervention	Specialized intervention services	Highly specialized services
Prevention initiatives	Day cares	Child care professionals	General practitioners, pediatricians	Special education programs	Secure treatment (MCSS)
Social/economic conditions	Families & children	Parents/self	Private practice psychologists, psychiatrists, social workers	Education programs in care/treatment facilities	
Biological factors		Recreational workers	Special education assessments, early identification, school-based counselling	Residential care & treatment (MCSS)	Dedicated inpatient child & adolescent units (MOH/MCSS)
Parental Perceptions	Recreational programs	Teachers & resource personnel	Family Service Association programs	Individualized hard-to-serve programming (MCSS)	
Access & geographic location		Public health nurses	Pastoral, YMCA & other voluntary sector programs	Child treatment, child & family intervention services (MCSS)	Dual & mixed diagnosis (MOH/MCSS)
Service responsiveness & design	Schools	General practitioners, pediatricians	School-based psychiatric, psychological, social work, speech & hearing services	Hospital outpatient psychiatry, pediatrics & family medicine (MOH)	
			Court clinics (MCSS/MOH/ Attorney General)	Non-residential crisis stabilization (MCSS)	Autistic services (MCSS)
				All MCSS-approved children's services	

Client flow towards greater disturbance and from local/generic services to regional/specialty services

is hardly a community organization that does not struggle in efforts to reduce family distress.

Continuous discussion about mental health for children takes place between the Ministry of Health and this ministry. Current topics range from the integration of hospital inpatient services for children and adolescents to program models for eating disorders and transitional-age youth issues. Both ministries recently endorsed the spirit of partnership in local planning through a document[4] originating from the Interministerial Committee on Children's Mental Health.

There has been a very active and fruitful collaboration provincially and locally over the last few years with the Ministry of Education in the development of educational programs in care and treatment facilities (Section 16 classes).[5] These classes allow children with special needs in MCSS programs who cannot participate in regular school classes to receive educational support. These educational programs are important examples of the partnership of MCSS and Education in the delivery of services to children with special needs, through local school boards and children's service agencies.

The spirit of collaboration and joint problem solving must continue to be developed and elaborated at the ministry level, particularly between Health, MCSS and Education with respect to prevention and early intervention programming. It is this Ministry's view, however, that local linkage and local planning are the preferred mechanisms to develop programs within an enabling regional and provincial context. Thus the main forum for this document will be planning and service delivery at the local level. It is there that organic or emergent program and service links between ministries will set the limits of any provincial planning initiative. The same holds true for co-ordination of efforts by MCSS service providers and self-help, voluntary and charitably funded organizations. These non-government funded organizations can only be factored in at local community levels.

This discussion paper is organized in a fairly straightforward manner. Chapter 2 scans the current resources, and briefly reviews broad client and service trends. Chapter 3 discusses the provincial picture of need, by examining epidemiological and service utilization data. Chapter 4 discusses

planning, and suggests a step-wise approach to local planning. The directions suggested in chapters 2 through 4 are highlighted in chapter summaries. Chapter 5 summarizes these principal directions, and details accompanying strategies for realizing these directions. The paper defines the directions in general terms rather than as precise objectives; while the directions constitute a provincial basis for planning and developing treatment and intervention services, the Ministry is interested in input through consultation prior to finalizing the strategies in a more detailed policy. The appendices contain a variety of information and statistical data to support the text.

Summary

The CFSA provides the value base for the development of treatment and intervention services for children. It sets out specific child and family service principles to this end, and provides a "flexible services" orientation for funding and planning purposes. In consideration of the impending expansion of treatment and intervention services, a number of other timely factors, treatment and intervention services are selected for discussion and development.

Notes

1. Investing in Ontario's Future: Strategic Directions for the Ministry of Community and Social Services, June 1986; and the companion piece, Corporate Plan. Ministry of Community and Social Services, June 1987.

2. Report on the Hard-to-Serve Child in Ontario. Prepared by A.R.A. Consultants for the Ministry of Community and Social Services, December 1981. See also Project Options: Who Does It Serve? What Does It Cost? What Are The Results? Collaborative report to Metro Children's Aid Society, Metro Catholic Children's Aid Society, Probation Services, and Central Toronto Youth Services, February 1986.

3. Services for Children with Mental and Emotional Disorders. A white paper tabled in the Ontario Legislature by the Honourable Matthew Dymond, 1966.

4. MCSS and Health released a joint statement on collaborative local planning mechanisms in 1986 entitled Joint Planning by the Ministries of Community and Social Services and Health for the Development of Comprehensive and Co-ordinated Children's Mental Health Services. Available through District Health Councils and MCSS Area Offices.

5. Education Programs in Government-approved Facilities for the Care and Treatment of Children with Special Needs. Ministry of Community and Social Services and Ministry of Education, December 1982.

"I would there were no age between ten and three and twenty, or that youth would sleep out the rest; for there is nothing in the between but getting wenches with child, wronging the ancientry, stealing, (and) fighting."

(Shakespeare, A Winter's Tale, 16th century A.D.)

2. THE SERVICE ENVIRONMENT

In considering directions for development in treatment and intervention services for children and families, an understanding of the current resource base is essential. As described below, treatment and intervention services are diverse and operate under a variety of auspices. The discussion that follows focusses on the emergence of complex and disturbing problems among children and families and the service trends that have developed in response to them.

The Current Resource Base

Specialized children's resources may be viewed from a number of perspectives. For the total range of expenditures on MCSS programs to children, including all services funded under the CFSA and also the child care funded under the Day Nurseries Act, the 1986-87 estimates call for spending of approximately $582 million. Restricting consideration to those programs limited to the Child and Family Services Act gives a slightly different perspective on resources. The resources available may be considered by agency (entire budget), or estimated by service category, in line with the flexible services philosophy of the CFSA.

Table 2, on page 18, provides a picture of the agencies funded under the CFSA that deliver child treatment and child and family intervention services. In addition, it indicates the important role played by the Ministry of Health in the delivery of child treatment programs through joint initiatives with MCSS and through services funded by Health alone. What are not captured here are the counselling and intervention services provided by private-practice physicians and medical specialists. Nor are any other private-practice professionals identified. (Appendix E sketches the Ministry of Health role and identifiable health organizations providing child treatment services for children. Appendix F indicates some Ministry of Education and school board services for disturbed children.)

Figure 2, on page 19, shows that per child expenditure through MCSS-operated and -funded agencies providing mainly child treatment and child and family intervention services averaged $67.53 for the province as a whole. Regional expenditures ranged from a low of $59 per child in the Southwest to

Table 2

PROVINCIALLY FUNDED AGENCIES THAT PROVIDE MAINLY CHILD TREATMENT AND INTERVENTION SERVICES

1986-87

Funded and/or Licensed by Ministry of Community and Social Services (MCSS)

95 Children's mental health centres (CMHCs)

56 Children's and youth institutions (CYIs) (including maternity homes)

Funded by MCSS and Ministry of Health (MOH)

4 CMHCs that share staff and facilities with hospitals

4 Joint CMHC-adult community mental health programs

3 Child and adolescent units in provincial psychiatric hospitals

Funded by MOH

20 Outpatient children's mental health clinics in public general hospitals

4 Child and/or adolescent inpatient units

3 Community mental health programs for 16-24-year-olds.

PROVINCIALLY FUNDED AGENCIES THAT MAY PROVIDE SOME CHILD TREATMENT AND INTERVENTION SERVICES

Funded and/or Licensed by MCSS

54 Children's Aid Societies

73 Probation and Aftercare Offices

Children's residential services, including:

36 detention homes

197 group homes (plus 140 extended family homes)

8 secure custody facilities

9 correctional group homes

Funded by Ministry of Health (MOH)

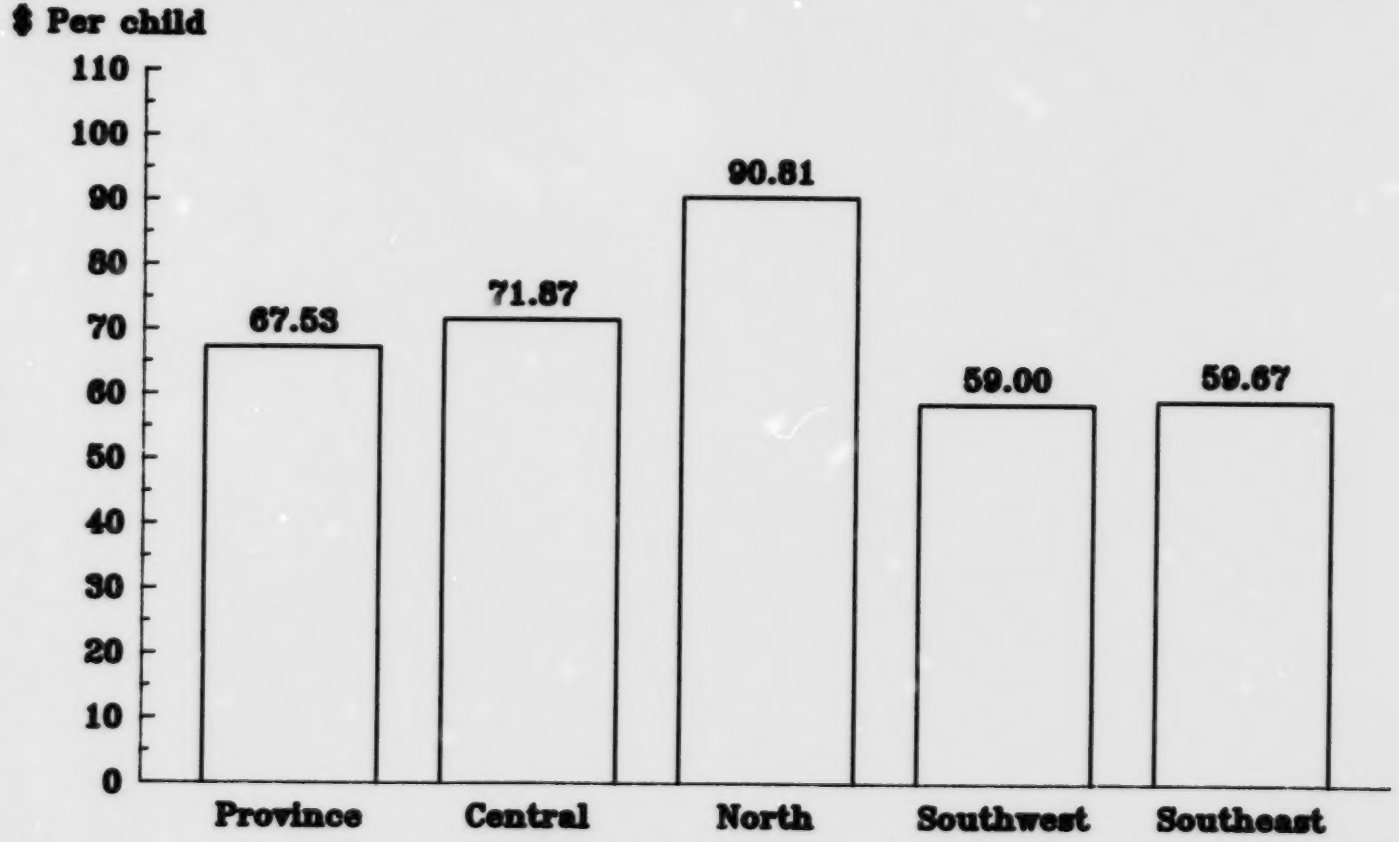
187 Public general acute hospitals of which 162 have pediatric services and 64 have psychiatric services (designated Schedule I facilities under the Mental Health Act)

380 Adult community mental health and addiction programs.

(Ministry of Education resources are identified in Appendix G.)

Figure 2

PER CHILD SPENDING ON CHILDREN'S MENTAL HEALTH CENTRES & CHILDREN'S & YOUTH INSTITUTIONS



Source : 1986 – 87 actuals
Ministry of Community and Social Services

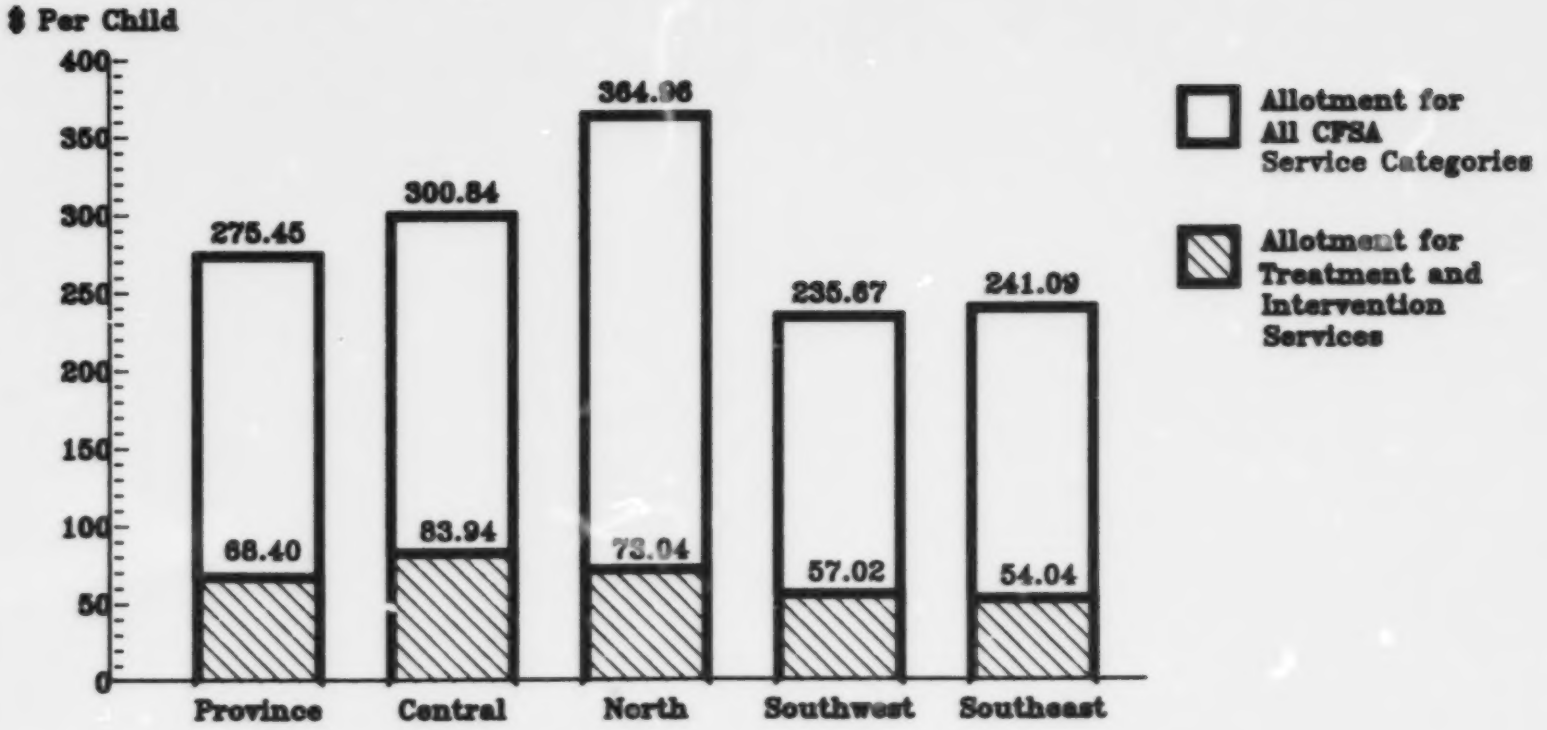
a high of $90.81 in the North. The agencies involved include children's mental health centres (CMHCs) and children's and youth institutions (CYIs). (Table III in Appendix G gives the background financial detail and area-level breakdowns as well.)

Another approach is to take a "flexible services" approach. Estimating the allotments across all the service categories of the CFSA, as shown in figure 3 on page 21, indicates much higher per child spending. Using this approach, the 1987-88 per child CFSA spending estimate is about $275.45. If only the treatment and intervention service categories are considered, however, the per child spending estimate is $68.40, very close to the agency average. The same rank ordering of regional differences prevails in the "agency"-based spending (figure 2) and the combined CFSA services estimate (figure 3). The rank ordering of regions changes, however, when only the treatment and intervention allotments for CFSA categories are considered. (Table IV in Appendix G provides both a detailed breakdown on allotments by service category and region and information on allotments that are not included in the estimate.) In allocations of new children's resources to regions, MCSS will consider a balanced approach that attempts to reconcile equity of resource distribution with unique regional needs.

While various provincial jurisdictions are currently estimating their children's services resource base, no comprehensive national or comparative data are available. Ontario is the only Canadian jurisdiction with a consolidated range of services for children and families with special needs and one of the few with a range of dedicated treatment and intervention services.[1] In the United States, the national per child spending on dedicated children's mental health service would appear to be about $9 U.S.[2] While Ontario would seem to have a reasonable service resource base in relation to the U.S. national average, we traditionally have spent relatively less on research and training on an ongoing basis than our neighbours to the south. In 1987, however, MCSS announced funding and support to launch the C.M. Hincks Training, Resources and Research Institute. It is hoped that this centre will develop as a leading training resource for treatment and intervention service professionals in Ontario. In addition, Ontario recently announced the development of a Child Youth and Family Policy Research Institute, which will provide a wide range of commentary on topics of interest to child and family public policy makers. MCSS has also been providing significant support to

Figure 3

PER CHILD TREATMENT & INTERVENTION ALLOTMENTS BASED ON ALL CFSA SERVICE CATEGORIES



Source : FPCA Allotments, June 1987.

the Child Epidemiology Unit at McMaster University. This unit is providing a range of extremely useful and provocative data related to the epidemiological dimensions of childhood psychiatric disorders. Some of these data will be considered in Chapter 3.

In the spirit of the CFSA, service development must adapt to a changing client and service environment. The development of treatment and intervention services must be sensitive to changing trends in child and family problems, but also in step with the broader emerging trends in services to disturbed children and families here and in other comparable jurisdictions.

Emerging Client and Service Trends

In developing directions for treatment and intervention services, what broad trends in child and family client characteristics demand a response? A detailed demographic and environmental scan appears in the MCSS global planning documents cited in note 1 to chapter 1 on page 12, and this paper does not reiterate the full range of trends identified there. Suffice it to say here that in spite of the apparent timelessness of Shakespeare's observations on youth, child and family problems do change somewhat.

The numbers of children in Ontario are decreasing, and family patterns are changing. Only 16% of Ontario families fit the traditional model - two parents, children, a father who goes out to work, and a wife who is at home. High divorce rates are coupled with increases in lone-parent households and blended and reconstituted families. Treatment and intervention services must maintain a flexible, responsive and evolving orientation to changing family needs and configurations.

As families' needs are changing, so are some of the childhood problems seen by children's programs working in the community. While the total child population is declining, life-saving and -supporting medical technology and the philosophies of de-institutionalization and non-institutionalization have resulted in increased numbers of populations in the community with special needs. Indeed, children's agencies report that their clientele are presenting more complex and disturbing problems, and this is undeniably in part attributable to the de-institutionalized populations. The more contemporary needs group, however, is the never-have-been institutionalized group in

different young client populations, who are increasingly recognized as challenging conventional wisdom and program design.[3]

Indeed, the Ministry's philosophy of the primacy of the family is reflected in the CFSA principles and its policies regarding community integration of specialized populations of disturbed children. MCSS has dramatically reduced training school numbers, and lowered the numbers and length of stay in residential treatment beds. These trends and the depopulation of institutions in the multi-year plan for the developmentally handicapped will present new challenges in designing community programs for children with complex physical, psychiatric, emotional, and behavioural problems. Implementing these policies will require more than a stretching of existing resources. The real challenge will be to stretch the imagination in the design and development of sophisticated new community programming models structurally linked to highly specialized professional and technologically sophisticated resources.

A number of trends in service and program development in the treatment and intervention area merit consideration in assessing new directions. A whole group of confluences has been reduced here to three broad and related trends, requiring recognition that these are oversimplifications of larger, more complex economic and social processes over the last ten years or so. These trends are:

1. a shift from a focus on individual psychopathology to a systemic and skill-based focus in assessment and intervention

2. improved co-ordination of specialized resources through contractual agreements between agencies and services, building on existing networks

3. empowerment of clients, consumer groups and local communities in the delivery of services.

The first trend, the shift towards a systems- and skill-based approach to assessment and intervention, marks a certain phase or paradigm shift in the development of treatment and intervention services. The presence of serious mental disturbance has not changed, nor has the need for sophisticated specialty services and their accompanying resource needs. Rather, there is a growing recognition that a pathology-focussed assessment, formulation and

treatment plan may make good sense as part of the picture for profoundly disturbed young people with traditional major mental disorders. This approach, however, must be coupled with an approach based on strengths and the development of skills necessary for daily living. This is true for profoundly disturbed young people and for the majority of young people and their families who experience transitional and episodic patterns of disturbance. For many young people, reframing their difficulty leads to an examination of the family, school and peer system to develop a comprehensive assessment and subsequent intervention and support strategy. Contemporary wisdom would suggest that sensitive and thorough assessments will lead to a focus on the skills, strengths and family system features to be harnessed in finding a solution to developmental crises.[4] This includes the focus on here and now, and forward-looking solutions, rather than a preoccupation with the past.[5] Again, this does not mean that the past is ignored, since the development of profound disturbance is usually preceded by significant history. Rather, the focus of intervention will tend to be here and now, and directed towards learning the skills to overcome or compensate for impairment.

This more circumscribed pathological focus mirrors the strategic reorienting of child psychiatry heralded in several sectors.[6] This reorienting appears as a move away from the huge range of childhood problems and intervention levels towards a renewed focus on diagnosis and treatment of major mental disorders, a related consultation role and increased emphasis on research and training. Some of these elements of balance between the pathological and the skill-development, educative approaches have been in place in European programs for some time.[7]

The increased focus on systemic points of intervention, broadened beyond the immediate family system, is perhaps best seen in primary prevention initiatives. The whole primary prevention thrust, increasingly more specific and sophisticated in the targeting of "at risk" populations,[8] represents a major challenge in developing new services. "At risk" is used here to refer to populations where there is good research evidence of increased risk for childhood disorders that may impair the child's effective functioning. This challenge extends beyond the boundaries of CFSA service agencies and beyond mandates across several ministries and levels of government. Reducing the prevalence of conduct disorders in "at risk" populations of children and youth, for example, may be more clearly effected by well-orchestrated socialization

and recreational programming, compensatory education and skill-based programs[9] than by traditional psychotherapeutic formulation and intervention.

MCSS has already identified a large number of target populations and intervention points for primary prevention.[10] Successful primary prevention demonstration programs have included programs developed for:

- o day care for infants of teen mothers
- o skill development for youths
- o parenting education
- o parent-child drop-in centres.

This focus on primary prevention is a key thrust in all areas of the Ministry. We have learned, along with our colleagues in many other jurisdictions, that prevention of childhood disorders is a complex field with a mixture of pitfalls and promising approaches. The initial focus on risk and protective factors has evolved into a formulation of psychosocial resilience as a bipolar chacteristic with risk at one end and invulnerability at the other. Michael Rutter[11] suggests that protective processes (and suggestions for intervention) need to be focussed around

1. altering risk factors
2. altering exposure to risk
3. reducing negative chain reactions
4. building self-esteem
5. improving opportunity structures.

Recent reviews on primary prevention suggest that successful programs have been developed for different target groups.[9,12] These include milestone programs for children at key preschool or school-age periods (such as competence building, Head Start-style programs); programs for high risk groups (such as children of divorce, or children of mentally ill or antisocial parents, or children of families on welfare); and community-wide programs, such as an entire school or residential neighbourhood where there are large numbers of at risk children and families. Others have suggested that competence building plus the development of social support and mutual help networks provide the most promising social and community interventions in improving child and family conditions.[12,13] In many of these interventions,

building on and between existing community services to children and families is the approach, as opposed to setting up new, stand-alone approaches to intervention.

The second trend, the linking together of resources, is one of the central service trends over the last few years in this and other jurisdictions. It is intimately tied up with the strong demand for treatment and intervention services. Identification of a child or family with serious problems initiates a competition for scarce resources. This child and family begin struggling to identify which service providers, professional groups and service funding streams are available and receptive to their needs. Historically, services to disturbed children in Ontario have moved away from regional centres, and have developed from multiple sources in the form of small, locally responsive treatment and intervention services. For this patchwork of services to function as a network with range, depth and responsiveness to the needs of disturbed children and their families, services must be linked together. Achieving a graded range of specialized resources that triage clients according to need requires not simply good will or community pressure, but a series of systemic mechanisms and written service agreements.

There is a particular need for mechanisms that allow clients with severe or chronic problems to have priority access to the most specialized, professionally intensive services, as depicted in table 1. Priority access mechanisms are referred to here as "gating mechanisms". Exchanges of services and clients between agencies or service providers through formal agreement are referred to as "docking mechanisms". The latter may involve in-kind exchanges between providers or purchased services.

Gating mechanisms seem especially important for access to scarce hospital beds and other resource-intensive, specialized residential, non-residential and professional consultation services. Agencies that have specialized resources (program, professional, research) are increasingly establishing docking agreements with sister agencies on the basis of case traffic by geographic area, and complementary needs and services. It is recognized that the organization and skill base associated with a hospital-based, high-technology, medically oriented program to stabilize psychotic and suicidal young people may differ substantially from those of a community-based agency serving a broad mix of client diagnostic groups that are intimately linked to

neighbourhoods and less formal helping structures in the community.[14] While both may offer needed treatment and intervention services, they perhaps legitimately will have different orientations and service philosophies. They also need structural links with each other that stretch beyond good intentions and friendly professional contact.

Docking mechanisms include letters of understanding covering specific reciprocal exchange of services. These mechanisms represent first responses to the challenges posed by the increasing numbers of children in the community with complex and unique needs resulting from de-institutionalization. Special agreements between agencies have become essential in the adult mental health community, where scarce specialized residential resources, hospital programs and case management programs have recognized their obvious mutual interdependence and specified contractual responsibilities to one another in writing. (Sample agreements are included in Appendix H.)

The co-ordinated development of docking mechanisms for and gating access to well-resourced, specialized assessment and treatment services recognizes the important role of the pathologically focussed approach in dealing with the most profoundly disturbed young people and their families. Forms of specialized service require specialized linkage to universal screening mechanisms to ensure that (a) the most serious disturbances are identified promptly and aggressively treated, and (b) the most seriously disturbed have continuously managed service between what may be diverse intervention and treatment services of short duration. Well-designed services for the most seriously disturbed are essential, as the seriously disturbed will always consume a significant portion of resources. These specialized services will also require a critical mass of concentrated professional research resources and the technology to link and apply this expertise in serving other service providers, with lesser resources, both in the same community and in more remote areas.

The third trend, towards empowerment, stems in part from the increasing focus on rights and due process reflected in recent legislation. It also stems, however, from the growing recognition that central governments have limited roles to play in the development of local services. Enhancing the involvement of local consumers in the design and evaluation of a spectrum of local

services is a growing phenomenon that can bring results by improving access to needed service, satisfaction with service, availability of manpower, and program designs, to achieve greater outcome effectiveness.[15] It also acknowledges the important roles and functions of self-help and voluntary agencies for disturbed children.

The notion of empowerment of clients, consumer and local community groups de-emphasizes "top-down" professional approaches to the less fortunate, seen variously as patients or clients. Rather, it emphasizes strategies that enhance people's sense of control over their own destinies. In this respect, community processes that foster a sense of competence, control and involvement constitute empowerment. Services exist to meet client need, and thus must be designed to take their needs and preferences into account. Sensitivity to the vital areas of culture and language is an important feature of respect for client and community need.

The whole focus on fitting services to the individual rather than trying to fit clients into services is a recognition of the importance of individual client need in driving service design. Particularly with more complex and seriously disturbed clients, designing individualized packages of service would seem to go hand in glove with a case-responsible individual who can "broker" multiple services. Case-responsible individuals can ensure continuity of service between different agencies and services.

Summary and Directions

This chapter reviewed the resources directed towards treatment and intervention services for children and families by looking at the agencies providing these services. It depicted per child spending for CMHCs and CYIs and, while recognizing that CFSA-based resources do not present a complete picture, estimated 1987 per child allotments by CFSA service categories to each region. The chapter then reviewed major client and service trends, and identified three major service trends over the last few years that bear consideration in developing treatment and intervention services. These trends are to: a systemic and skill-based focus in assessment and intervention; improved co-ordination of specialized resources; and empowerment of clients, consumer groups and communities. They lead to the suggestion of these directions at the level of children and families:

Direction 1: Responsiveness of service to clients and local communities will be the cornerstone of all initiatives.

Direction 2: Continuity of service to clients is to be actively promoted.

Notes

1. Doherty, G. Provision of Services to Children with Behavioural or Emotional Problems. Prepared for the Alberta Department of Social Services and Community Health. Doherty Social Planning Consultants Ltd. See also Fewster, G. Expanding the Circle: A Community Approach to Children's Mental Health. This document distributed in 1986 by the Alberta Department of Social Services and Community Health details the Alberta approach to developing a dedicated range of treatment and intervention services for children.

2. U.S. Congress, Office of Technology Assessment. Children's Mental Health: Problems and Services: A Background Paper. Washington, December 1986.

3. For an interesting example and analysis see Bachrach, L.L. Young adult chronic patients: An analytical view of the literature. Hospital and Community Psychiatry, 1982, 33(3), pp. 189-197.

4. Carter, E.A. and McGoldrick, M. (eds.). The Family Life Cycle: A Framework for Family Therapy. New York: Gardner Press, 1980.

5. Rae-Grant, N.I. Longevity, mobility, and spare parts: The future imperfect and human service delivery. American Journal of Orthopsychiatry, 1972, 42(5), pp. 835-846.

6. See Phillips, I. Child Psychiatry in USA. International Child Mental Health, I, 1986, p. 13. Newsletter of the World Psychiatric Association, Child and Adolescent Section.

7. Linton, T.E. The European Educateur model: An alternative and effective approach to the mental health of children. Journal of Special Education, 1969, 3(4), pp. 319-327.

8. Buckner, J.C., Trickett, E.J. and Corse, S.J. Primary Prevention in Mental Health: An Annotated Bibliography. Rockville, Maryland: U.S. Department of Health and Human Services, National Institute of Mental Health, 1985. In the context of the current paper, primary prevention or intervention refers to interventions with groups of children and families who are at increased risk for childhood problems, but have not yet developed significant problems. Secondary prevention or intervention refers to inverventions designed to eliminate problems once they have arisen and been detected. Tertiary prevention or intervention refers to remedial or rehabilitative interventions designed to improve the level of function for children who have chronic disturbances.

9. Offord, D.R. Prevention of behavioral and emotional disorders in children. Journal of Child Psychology and Psychiatry, 1987, 28(1) 9-19. See also Psychiatric Epidemiology and Prevention: The Possibilities. National Institute of Mental Health and the Neuropsychiatric Institute, University of California, Los Angeles, 1985.

10. The State of the Art: A Background Paper on Prevention. Prepared for the Ministry of Community and Social services by Dr. N. Rae-Grant, October 1979. In 1978, MCSS designated prevention as a priority in children's services. This has produced a series of prevention programs, commented upon in Report on Primary Prevention Initiatives in Children's Services, Ministry of Community and Social Services, July 1984, as well as Planning and Management Considerations for Prevention in Children's Services, Ministry of Community and Social Services, September 1985. These documents specify target populations and program interventions that hold promise for reducing disorder.

11. Rutter, M. Psychosocial resilience and protective mechanisms. American Journal of Orthopsychiatry, 1987, 57(3), pp. 316-331.

12. Gesten, E.L. and Jason, L. Social and community interventions. Annual Review of Psychology, 1987, 38, pp. 427-460.

13. For examples, see D'Augelli, A.R. et al. The Community Helpers Project: A description of a prevention strategy for rural communities. Journal of Prevention, 1981, 1, pp. 209-224, and Whittaker, J.K. Formal and informal helping in child welfare services: Implications for management and practice. Child Welfare, 1986, LXV (1), pp. 17-25.

14. Naparstek, A.J., Biegel, D.E. and Spiro, H.R. Neighborhood Networks for Humane Mental Health Care. New York: Plenum, 1982. See also Emerging Trends in Mental Health Care for Adolescents. U.S. House of Representatives Select Committee on Children, Youth and Families, 1985.

15. Cappel, L.W. Satisfaction levels of recipients and providers of children's mental health services. The Journal of School Health, December 1981, pp. 659-662. See also Schwab, M.E. and Stone, K. Conceptual and methodologic issues in the evaluation of children's satisfaction with their mental health care. Evaluation and Program Planning, 1983, 6, pp. 283-289.

"We need words to keep us human. Being human is an accomplishment like playing an instrument. It takes practice... Our needs are made of words: they come to us in speech, and they can die for lack of expression. Without a public language to help us find our own words, our needs will dry up in silence. It is words only, the common meanings they bear, which give me the right to speak in the name of the strangers at my door."

Michael Ignatieff
The Needs of Strangers: An essay on privacy, solidarity, and the politics of being human. Markham, Ont.: Penguin Books, 1986, pp. 141-2.

3. THE NEED FOR SPECIALIZED SERVICES

Michael Ignatieff's comments lead us into a discussion about who needs specialized treatment and intervention services. In speaking on behalf of the strangers at our door, we must be very careful about cavalier uses of the word need. Each of us has seen the heartache and frustration of parents trying to deal with a frightened and "omnipotent" child. A few of us have experienced the bewilderment and anguish of an adolescent and family coming to grips with an emerging schizophrenic disorder in young adulthood. Mercifully, fewer still of us have sat down to offer weak comfort for the family of the young person who ended his or her own life or attempted to end the life of someone else. It is easy to see need in living human beings we interact with. It is another matter to identify what levels of need and distress should be alleviated in the thousands and potentially millions of "strangers at the door" on whose behalf MCSS might be asked to speak.

How to determine the need for treatment and intervention services has been historically a focus of animated discussion in the service sector, the research sector and the lay community. In this province, much of the current discussion is being stimulated by the rich output of information from the Ontario Child Health Study (OCHS).[1] The OCHS, an epidemiological study of social factors and psychiatric disorders in the child population, has given us a province-wide base of information on which to begin an examination of planning issues such as: who is disturbed, who needs service, who uses services, and so on. Some understanding as to whose needs we are trying to meet must then be coupled with an understanding of how local communities plan to meet needs and what kind of a range of services might be optimal in responding to the needs to be met.

Identifying Who Needs Service

There are a number of ways to define need.[2,3] Each has limitations.

"Felt need" means the same as "want". It is an individual's subjective assessment of his own requirements. This definition has the advantage of giving credence to the opinions of those most affected by human services,

users and potential users. There are several limitations to this approach. People cannot formulate a "want" for assistance if they lack information about the availability of assistance. Not all interventions are wanted (e.g., child protection, involuntary certification). While a potential recipient of assistance may know that he needs help, he may be unable to define his need sufficiently clearly for it to be matched to the appropriate resource. This is most true where the person is very young, or severely developmentally handicapped, or mentally disturbed.

"Expressed need" is like felt need, but has been translated into a service demand. This definition allows for the use of such data as case counts and waiting lists, which are readily available, rather than requiring a survey of the general population. A number of treatment and intervention services in Ontario report waiting lists. Estimates of expressed need depend on individual awareness of program availability and the ability to request required help. Measurement of expressed need can lead to overestimation or underestimation of need. Also, people may hesitate to express need when a stigma is attached to the related service (e.g., assistance for drug abusers or child abusers).

"Comparative need" is a concept that assumes that if people with certain characteristics have a range of certain services available and others with similar characteristics do not, the latter are in need. In terms of community need, one can examine social characteristics of an area such as the number of single parent families, and compare these with the number of services available to this group. (Appendix I, for instance, provides an example of a CFSA-based social indicator formula applied to all counties in Ontario.) Comparative need assumes that those receiving service require that service, or, indeed, any service. It also assumes that those receiving service receive effective levels and quality of service. If one geographic community has more services than another in relation to a particular social indicator, this does not necessarily mean that the former community is appropriately serviced. It may be under-resourced or over-resourced. Also, its service responses to a particular problem may be inappropriate to the needs of the latter community.

"Normative need" is need as defined by experts or professionals. This definition requires the setting of desirable standards that, if unmet, indicate that an individual is in need. Normative need, however, is open to charges of

paternalism or elitism (i.e. because a small segment of the population is determining the needs of the rest of the population).

Clearly, there is no simple definition of "need" that we can all rally around in planning either provincially or locally for treatment and intervention services. It is essential to get some sense of the scale of need, however, to determine how need is to be addressed.

Moreover, the use of "scientific" methodologies in determining need does not guarantee that they will be useful for planning purposes. Planning decisions are profoundly influenced by factors other than objective allocation strategies or need hierarchies. Also, survey numbers are easily misconstrued as cold data, inhumane and sickness- or economically focussed, and they do not paint human faces on the children and families who need or use our services. What is more, data rarely convey systemic information. Data are one- or two-dimensional, while child and family problems are systemic and multi-dimensional. Finally, there are always problems with data in all forms. Everyone becomes a methodologist when priorities for scarce resources are argued on the basis of data. The alternatives to objective methods, however, amount to rhetorical or emotional arguments, and are even less inspiring.

Having said all of that, this paper will be developing a picture of need based on data from two major sources: (1) data on the Ontario Child Health Study and (2) data on utilization of residential and selected non-residential services in the MCSS and the Ministry of Health data systems.

The following data from the Ontario Child Health Study will be considered:

- prevalence of childhood behaviourial or emotional disorder
- utilization of social/mental health services
- utilization of ambulatory medical care
- utilization of special education
- correlates of disorder.

The following data from the MCSS and Ministry of Health systems will be considered:

- o utilization of community- and hospital-based residential resources
- o utilization of non-residential services in children's mental health centres
- o referral patterns for children's mental health services.

These constitute the best and most comprehensive data available provincially, notwithstanding the measurement limitations of each source. Significant measurement errors are associated with MCSS information systems. These data, however, are not completely unreliable, and give us realistic impressions of the scale of the variables under consideration. In terms of the categories of need, they convey expressed need, the best of normative need and a measure of felt need.

The 1983 Ontario Child Health Study included 3,294 children 4 to 16 years old. Using diagnostic criteria from DSM III[4] reflected in the basic pool of items in the Child Behaviour Checklist, estimates of prevalence of childhood psychiatric disorder were established. The categories of disorder were set as conduct disorder and hyperactivity (externalizing disorders), and neurosis and somatization (internalizing disorders).

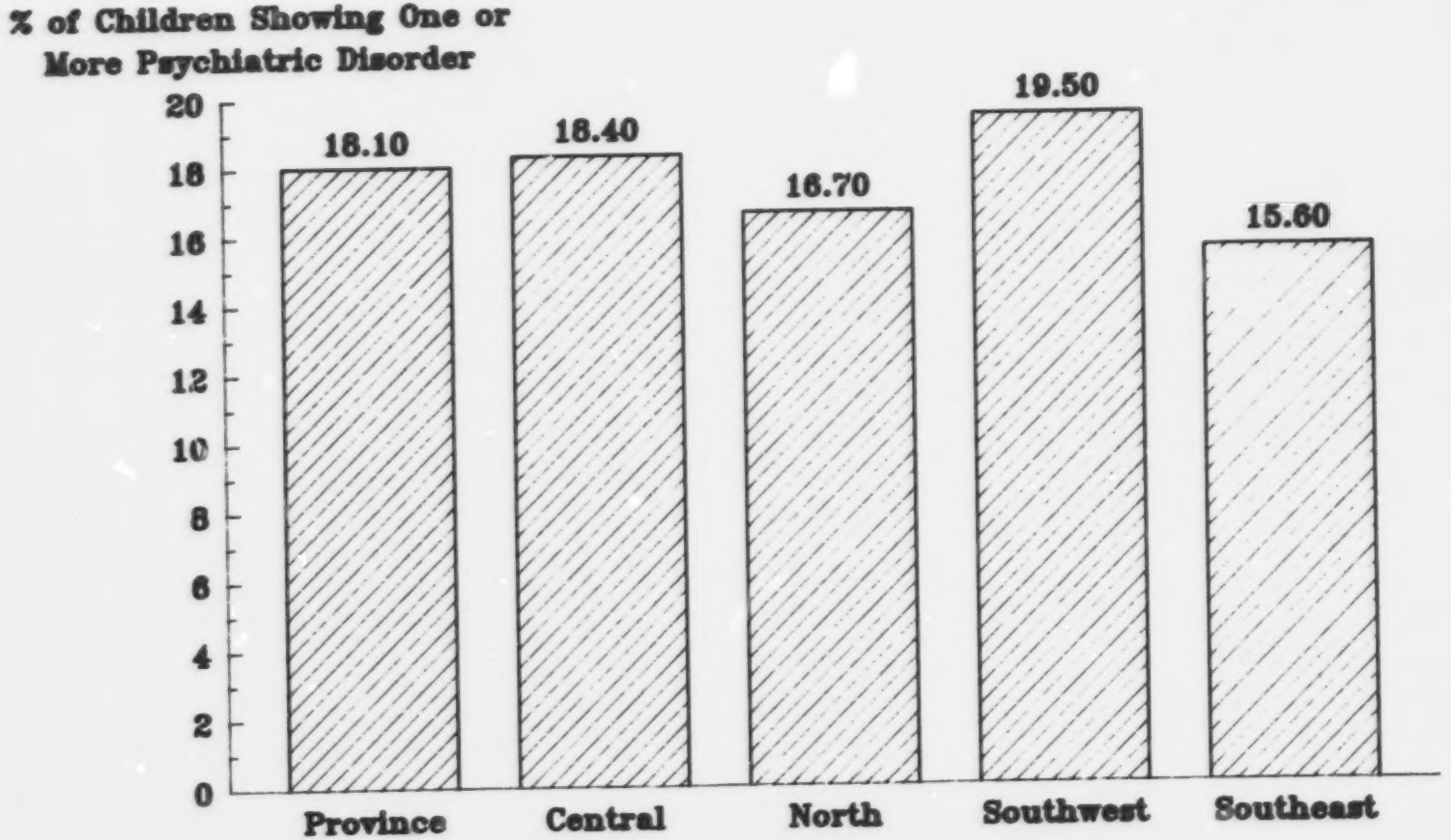
This study, funded by MCSS and carried out by Dr. Dan Offord and colleagues at the McMaster Child Epidemiology Unit, yielded an overall estimate of provincial prevalence of one or more disorders at 18.1%. MCSS regional differences were not significant (see figure 4, on page 37). This rate is consistent with a number of other studies and the findings of a recent German epidemiological study of childhood disorders.[5] Clinical validation was part of the OCHS technique for corroborating thresholds for disorder.

Does this mean that 18.1% of all children in Ontario need some treatment or intervention service? It would appear not, since the presence of a specific disorder does not necessarily impair an individual.[6,7] Where disorders do impair people, the rates are not comparable across all disorders. We know, for example, that problems associated with conduct and developmental disorders tend to be persistent from early to late childhood, whereas neurotic and hyperactive disorders tend to diminish spontaneously with age[1,7,8] although there are significant sex differences from study to study.

The different developmental courses of childhood disorders are critically important for the population and program focus in developing services. The

Figure 4

PREVALENCE OF ONE OR MORE CHILDHOOD PSYCHIATRIC DISORDERS BY REGION



Source : Ontario Child Health Study, 1983

second round of survey data from the OCHS has recently been collected as part of the follow-up four years after the original survey. These data promise to give us a more complete picture of the persistence and changes in prevalence of childhood disorders in Ontario by studying the pattern of change in the same individuals. We know, for example, that certain disorders arise early, are persistent throughout childhood, and result in long-lasting impairment and disability. There are compelling reasons to try to intervene early on with these conditions, in terms of reducing both suffering and the burden of dependence on services. But to return to the question of whether 18% of Ontario's children need service, the discussion above has already established that not all disorders impair young people, nor are they all persistent. Furthermore, not all disturbed children or their families want or will use specialized services if offered. Some prefer to avoid services altogether, and others prefer to use more familiar helping agents such as G.P.s or their pastor, and so on. Even if we could provide service to all of these young people, it is not likely that our services would be all that effective in reducing disorder. Let us turn, therefore, to some examination of what we know about service utilization in Ontario.

The OCHS has shown that here as in other jurisdictions, service use seems heavily driven by parental perceptions of the child's need (felt need). Service provider discretion in judgement of who needs most (gatekeeping) and admission judgements about who might best benefit from treatment and intervention are other factors that we know from other jurisdictions influence utilization patterns.[9]

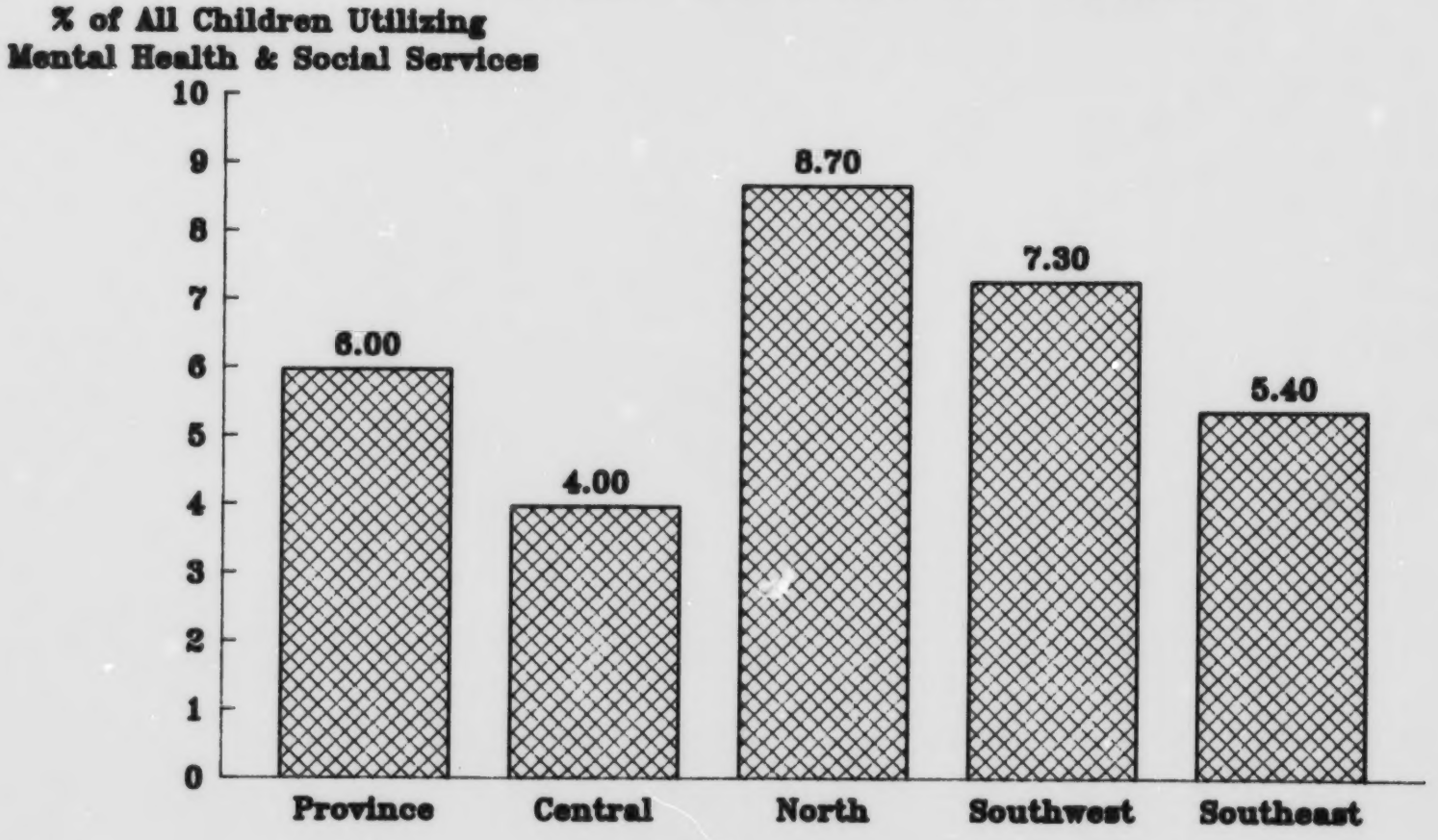
We should now consider some of the OCHS and MCSS utilization findings in considering need. The OCHS examined utilization of four service groups:

1. hospitalization
2. special education at school
3. ambulatory medical care
4. mental health/social services.

Since most treatment and intervention services are identified in the last service category, mental health and social services, we will consider patterns of service use in this category (see figure 5 on page 39). This category was defined by a parent report that the child was the focus of a consultation

Figure 5

UTILIZATION OF MENTAL HEALTH AND SOCIAL SERVICES BY REGION



Source : Ontario Child Health Study, 1983

with a professional from a mental health or social service (mental health clinic or agency, private practitioner, such as a psychiatrist, psychologist or social worker), and included the Children's Aid Society (CAS), or Family Services Association (FSA), or a service linked to the courts (probation services or court-linked agency) or some other related child service not included in the previously mentioned mental health/social service agencies. The utilization of this overall service category is relatively low (6% of all children). Consideration of the disordered population alone shows that only 15% obtained these specialized mental health or social services in the last six months. Children with disorders were also three times as likely as the general population to obtain social or mental health services in the past six months. Of all children who used this service, roughly half had one disorder or more and half had none.

The rates of utilization of mental health/social service are significantly different from region to region. The North has a higher rate of use of these services by non-disordered children, while the Central region uses them least, and has few non-disordered children using them. One speculates that the many non-disordered children may have been seen by the CAS and FSA, presumably because of urgent situational needs.

More than half of the disordered children received ambulatory medical care (saw doctors), and about a quarter of the disordered group received special education services. Other data indicate that these two professional groups are seeing large numbers of children and referring them for specialized services. These two major referral sources are reflected in referral trends in children's mental health programs depicted in table IV in Appendix G. The major referral sources other than families themselves are schools and practising clinicians other than psychiatrists including general or family practitioners. Schools and G.P.s see perhaps the largest numbers of disturbed children, and along with public health, constitute the core group of professionals who see all children. We already know that children with disorders are more likely than their peers to see their doctor for behavioural and emotional problems as well as minor illnesses.[10] In the OCHS, children with internalizing disorders were more likely than other children to have been seen by mental health and social services and also by an ambulatory medical service. The OCHS has not yet given us a precise estimate of who uses which specialized treatment and intervention resources. We can get some

impressions of this specialized service utilization from Ministry-based data systems.

When we look at Ministry-based data systems, one of the most impressive observations is how infrequently MCSS services and Health and MCSS hospital-based psychiatric inpatient services are used in comparison with special education or ambulatory medical care. From table III in Appendix G, it may be noted that the provincial averages in utilization of specialized residential services are very low (CMHCs 0.1%, CYIs 0.09%). If all the specialized residential resources employed by MCSS and Health are considered, the numbers are still low (<2%). Non-residential utilization data (<2% in CMHCs) parallel the utilization rates in Nova Scotia for children seen in mental health clinics.[11] These data raise the question of who is actually utilizing treatment and intervention services, and which client populations might most usefully be served by these programs.

For the purposes of provincial planning in this sector, areas clearly requiring further research and careful analysis include:

1. the nature of disturbance in children currently receiving child treatment and intervention services
2. what program characteristics enable or impede the utilization of these services
3. how the population using specialized services compares with those not using the services
4. the relationship between disorder and impairment
5. which populations we are programming for, whose needs we are trying to meet.

This brings us back to the starting point of the question: who "needs" service? For the purposes of this discussion, it might better read: for whom is it wisest for treatment and intervention services to develop programs and interventions? This question assumes that these services should provide some distinct or specialized function, as well as recognition that not every child who has a disorder can or should necessarily receive a specialized treatment and intervention service. One consideration would be to target populations of children who are impaired or where there is good evidence that they are likely to become impaired. Since treatment and intervention services are not

the main point of contact for service for most of the children who are disordered, nor are they necessarily the preferred option of many families, an important related strategy issue is how to build the services in this sector to complement existing service utilization paths and facilitate client access to preferred services most effectively. The proposal here is to develop provincial service targets for certain populations of children, rather than attempt to serve all "needs." This approach would be fully developed by taking the following steps:

- o identify target populations
- o involve other significant providers serving this population to "gate" these populations to treatment and intervention services
- o actively support an enhanced role of other sectors and actors in serving the remaining population.

Primary, Secondary and Tertiary Intervention

To target specific populations, we must begin by questioning the relative emphasis on primary, secondary and tertiary program interventions. Take tertiary intervention: should treatment and intervention services be directed at the seriously and most chronically disturbed? In referring to the serious and chronically disturbed, the intention is to refer to the persistence or early onset of childhood problems and the severity of impairment.[4] After all, the most disturbed and disturbing young people seem to consume a large portion of children's resources, and we often seem to provide a less than thoughtful response to their needs.[12] There may be another basis for considering them for targetting, since those disorders that emerge early and persist, or are most chronic, are conduct disorders, some developmental disorders and a number of debilitating and infrequent major mental disorders such as autism, schizophrenia and affective psychoses*.[5,8] These are the kinds of problems that appear to pose the longest burden of human suffering, and the greatest burden for service provision and dependence over a lifetime.

---

* Estimates of prevalence for autism, schizophrenia and affective psychoses are quite low[13]:

Disorders	Ages 10-14	Ages 15-19
Autism	.05%	N.A.
Sschizophrenia	.004%	.06%
Affective psychoses	.003%	.04%

In the case of conduct disorder, there is some historical tension over who should serve the most seriously and chronically disturbed. Among the child protection, children's mental health and young offenders service streams, tension has always existed regarding responsibility for these young people. This has been reflected in diagnostic categories tied to legislative mandates that provide ambiguous role distinctions for agencies in the provision of treatment, care, management, corrective parenting, or rehabilitation of seriously disturbed children. This dynamic tension is also partly attributable to the frustration of service providers in the face of the remarkable resistance of many chronically disturbed young people to conventional treatment and intervention approaches.[9,12,14] This resistance, however, in no way detracts from the requirement for sophisticated treatment and intervention programming, and consultation in effective management of these youngsters. Nor does it obviate the need for research priorities regarding interventions with the most disturbed and disturbing young people.

Despite the lack of dramatic outcome effectiveness, it is clear that publicly funded MCSS children's programs will continue to be mandated to provide service to the most seriously and chronically disturbed. It is very often the children with serious conduct disorders who cross service streams from child welfare to young offenders to treatment and intervention. In other words, we will have to serve these children, and we had better design our services to do this job well. Moreover, we had better design our interventions to begin at the earliest possible age with children and families likely to suffer serious and chronic disturbances. This will require targetting at risk populations and those who have demonstrated impairments from an early age. The intention would be to reduce the absolute numbers of children developing serious and chronic problems and also to reduce the burden of dependence and suffering for those whose problems begin at an early age. However, there are ways we may more imaginatively co-ordinate and design quality services to this population in efforts to achieve the highest possible levels of independent function. The challenge is to discover which interventions, in what circumstances, show some effectiveness with chronically disturbed youngsters.

In the area of secondary prevention or intervention, it is precisely the concern about "treatability" that has led some to the position that services should be tailored more to those less disturbed populations and diagnostic

groupings who can clearly "benefit" from treatment or intervention. Treating less than seriously disturbed children raises the risk of "creaming" the easier clients or serving professional interest rather than those most in need. Moreover, the paucity of good data on the state-of-the-art effectiveness of various program interventions[15] would seem to limit the credibility of this as a broad strategic approach.

Data from the German study previously cited, for example, indicate that clients who received intervention actually had poorer outcomes than those who had none.[5] This finding is somewhat inconclusive, however, since it is likely that some self-selecting occurred in relation to which clients requested services. This finding does underscore the importance of considering factors such as spontaneous remissions in selecting population targets. For a clearer picture of childhood emotional disorders, their natural history is needed to determine which are transitory and which are not, which are preventable and which are treatable, in order to more clearly target who most benefits and by which methods. For those that are not preventable or treatable, the issue is how to provide palliative service. While hyperactive and neurotic children may have very compelling needs at particular times, there may be a need to keep interventions with these children strategically brief, and screen for the most difficult, since some of their problems would appear to remit in later adolescence without dramatic intervention. In the case of secondary forms of prevention, "an ounce of prevention is worth a pound of cure" only makes sense in dealing with problems that do not spontaneously remit as part of their natural history, or where the accumulation of risk factors is highly ominous.

Rutter and his associates[16] have found children with just one family or personal characteristic associated with risk to be no more likely than other children to have a problem. However, when two risk factors occur together, the risk becomes substantial, and several times greater with the presence of each additional risk factor. In general terms, the OCHS has demonstrated the same kind of additive effect for risk, particularly for externalizing disorders. The strongest predictors of risk from the OCHS are identified[1] by rankings of "relative odds" (R.O.), a measure of the strength of association between the indicator and the presence of one or more childhood psychiatric disorders. Some of the characteristics most strongly indicative of risk are family dysfunction (R.O. 2.9), living in a family on welfare (2.8), living in subsidized

housing (2.6), having a chronic medical condition (2.4), and having few friends (2.2). Secondary forms of intervention would seem justifiable where the risk factors are clearly stacked up in a manner predictive of more serious or chronic disorder. In such cases, brief intervention designed to reduce the chain of events leading to more serious or chronic problems seems both desirable and genuinely preventive.

Finally, there is the growing perspective that primary prevention should have highest priority in program development, since reducing the prevalence of disorders in "not yet disturbed" populations is overwhelmingly the preferable approach.[17] George Albee describes primary prevention through a homespun test of intelligence. Given a bathtub into which water is flowing, an individual is given a cup to empty the water out. The intelligent solution to the problem is to turn off the tap. In the children's area, reducing the influx of disturbed children seems infinitely more sensible than trying to treat the casualties of childhood. Primary prevention has already been identified as a Ministry-wide direction within MCSS. Evaluation of primary prevention programs, however, has not always been as rigorous as it needs to be. Moreover, while some disorders sensitive to socialization processes appear responsive to prevention initiatives, there is little evidence that those infrequent and debilitating major mental disorders referred to earlier can be prevented with our existing knowledge base.[18] The preliminary analysis of predictive factors from the OCHS, however, gives us extremely useful targets for prevention programming. The first study summary[1] gives a rank order of odds for predicting disorders in the presence of certain factors. The independent contribution of each of the markers for disorder will be identified in a second provincial summary of markers for disorders derived from the OCHS. This new summary entitled Children at Risk will appear in 1988. The risk factors or markers that look most promising in terms of intervening with large identifiable groups at high risk include:

1. being from a family on welfare
2. living in public housing
3. being a single mother.*

---

* It is worth noting that when income is controlled for, being a single mother is no longer a strong predictor for disorder.

The design of successful prevention approaches for such groups in Ontario must be carefully built on successful programs here and elsewhere. Comprehensive intervention and outcome effectiveness measures must be built into the design of such initiatives if they are to deliver on the great promise they hold.[19]

From this brief consideration of the relative policy merits of primary, secondary and tertiary intervention, we proceed to consideration of which populations might best be targetted in developing child treatment and child and family intervention services. Certainly, the chronic and most seriously disturbed group requires intervention from the earliest points of identification possible. Continuity of service to members of this group also would appear important since many will impinge intermittently but predictably on the service system and its most heavily resourced programs as they grow up. Targetting the seriously disturbed for detection and intervention at the earliest possible age, and maintaining contact with them through case management, are clearly important steps in reducing their burden of suffering, and helping them achieve highest levels of independent functioning later in adolescence.

Many young people with transitional disturbances seek service through treatment and intervention services. It is desirable that these services screen such young persons and their families carefully to give priority to those with an ominous clustering of risk factors, while stimulating the capacity of other service providers to serve those whose risk factors and protective factors indicate more promising outcomes. Ambulatory medical care services and educationally based services, as well as voluntary sector, paraprofessional, lay, and client-based service groups are important resource partners. MCSS as well as treatment and intervention services should encourage them both in principle and programmatically in facilitating service to the large numbers of less disturbed, transitionally disturbed and non-impaired young people who nonetheless experience real distress.

Targetting at risk populations with known effective early intervention methods through clearly evaluable primary prevention methods is also desirable. Support and facilitation of these same functions in other service and government spheres are related and important activities.

The following would then appear to be important population group and program emphases in the development of treatment and intervention services across the province:

- o at risk populations: primary prevention methods
- o youngest identifiable disturbed or impaired children: early intervention
- o seriously and chronically disturbed populations: hard-to-serve programs.

Service to remaining populations could be supported and stimulated through a variety of linkage arrangements with publicly funded service providers, for example, G.P.s, hospitals, schools and day cares, and non-publicly funded voluntary organizations.

The emphases on primary and tertiary methods through targetting of specific populations are not meant to erode the role of existing services. Rather, the intention is to consolidate over time the focus on these population groups as strategically our wisest investment of human and non-human capital. In fact, many programs already reflect these emphases, and experience elsewhere indicates that careful targetting can be effective,[19] and influence utilization patterns in favor of those most in need.[20]

These relative emphases in population groups and program activity can best be supported by careful planning of the development of services. The hub of this planning is the area-level administrative structure within MCSS.

Summary and Directions

The identification of who needs service is a complex and value-laden notion that requires careful consideration. While prevalence of childhood disorders and utilization data are not absolute indicators of need, they probably represent the fairest estimates of relative need at our disposal. The OCHS indicates that about 18% of all children in Ontario have one or more significant emotional and behavioural problems, while only a small percentage actually receive specialized treatment and intervention services. This leads to a discussion of the need to specify the relationship between impairment and disorder. It also leads to an examination of the utilization of other major and key actors that provide counselling and other services to children and families. A review of arguments in favor of primary, secondary and tertiary

forms of intervention follows. This leads to specific suggestions for program design and target populations:

Direction 3: The delivery of primary prevention programs with "at risk" populations will be encouraged.

Direction 4: Detection and early intervention with the youngest identifiable children with serious and chronic behavioural/emotional problems will be encouraged.

Direction 5: Co-ordinated and responsive services for seriously and chronically disturbed children and youth will be encouraged.

Notes

1. Ontario Child Health Study: Summary of Initial Findings. Ministry of Community and Social Services, 1986. A second sampling of the same children four years later is now being analysed, and promises interesting findings. See also: Boyle, M. et al. Ontario Child Health Study: I. Methodology. Archives of General Psychiatry, 1987, 44, pp. 826-831; Offord, D. et al. Ontario Child Health Study: II. Six-month prevalence of disorder and rates of service utilization. Archives of General Psychiatry, 1987, 44, pp. 832-836.

2. Clayton, S. Social need revisited. Journal of Social Policy, 1983, 12 (2), pp. 215-234.

3. McKen, P. Community Needs Assessment: Why, What and How. Ministry of Community and Social Services, Children's Policy, March 1982.

4. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Third Edition. Washington, 1980. We can operationally define impairment as it is used in the current paper in relation to Axis V of DSM-III (highest level of functioning in past year). Severe impairment would include levels 6, 7 and beyond on Axis V of DSM-III or less than 40 on the Global Assessment Scale of DSM-III-R (see Third Edition, Revised. Washington, 1987).

5. Laucht, M. and Schmidt, M.H. Psychiatric disorders at the age of 13: Results and problems of a long-term study, in B. Cooper (ed.). Psychiatric Epidemiology. London: Croom Helm, 1987.

6. Richman, A. and Barry, A. More and more is less and less: The myth of massive psychiatric need. British Journal of Psychiatry, 1985, 146, pp. 164-168.

7. Richman, A., Boutilier, C. and Harris, P. The relevance of socio-demographic and resource factors in the use of psychiatric in-patient care in the Atlantic Provinces of Canada. Psychological Medicine, 1984, 14, pp. 175-182. See also Richman, A. Assessing the need for psychiatric care: A review of the validity of epidemiological surveys. Canadian Psychiatric Association Journal, 1966, 11(3), pp. 179-187.

8. Golumbek, H. et al. A longitudinal study of disturbed and nondisturbed children from pubescence into late adolescence. In press.

9. Knitzer, J. Mental health services to children and adolescents: A national view of public policies. American Psychologist, 1984, 39(8), pp. 905-911.

10. Goldberg, I.D., Regier, D.A., McInerny, T.K., Pless, I.B., and Roghmann, K.J.: The role of the pediatrician in the delivery of mental health services to children. Pediatrics, 1979, 63(6), pp. 898-909. See also Nader, P.R., Ray, L. and Brink, S.G: The new morbidity: Use of school and community health care resources for behavioral, educational and social-family problems. Pediatrics, 1981; 67, pp. 53-60.

11. Richman, A. Mental Health Services for Children and Adolescents in New Brunswick. New Brunswick Department of Health, Mental Health Services, 1984.

12. The Hard-to-Serve Child in Ontario. Prepared by A.R.A. Consultants for the Ministry of Community and Social Services (note 2, chapter 1).

13. Statscan data from Bland, R. The long-term mentally ill: An epidemiological perspective. Paper presented to the Canadian Mental Health Association consultation on perspectives on the long-term mentally ill. Toronto, 1982. Estimates on autism from Wing, L. The prevalence of early childhood autism: comparison of administrative and epidemiological studies. Psychological Medicine, 1976, 6, pp. 51-64.

14. Shamsie, J. Antisocial adolescents: Our treatments do not work -- where do we go from here? Canadian Journal of Psychiatry, 1981, 26(5), pp. 357-364.

15. Rutter, M. Psychological therapies: Issues and prospects, in S.B. Guze et al. (eds.). Childhood Psychopathology and Development. New York: Raven Press, 1983. A more developed review of outcome effectiveness and program design considerations was provided by Gillian Doherty in Three Decades of Change: The Evolution of Residential Care and Community Alternatives in Children's Services. Ministry of Community and Social Services, November 1983. A comprehensive and topical review of treatment effectiveness by target group and method is provided in Children's Mental Health: Problems and Services: A Background Paper (note 2, chapter 2).

16. Rutter, M. and Quinton, D. Psychiatric disorder: Ecological factors and concepts of causation. In H. McGurk (ed.). Ecological Factors in Human Development. Amsterdam: North Holland Publishing, 1977. See also note 11, chapter 2.

17. Albee, G.W. Preventing psychopathology and promoting human potential. American Psychologist, 1982, 37(9), pp. 1043-1050.

18. Glasscote, R.M. Commentary: Talking sense about prevention. Hospital and Community Psychiatry, 1981, 32(12), p. 823.

19. Guralnick, M.J. and Bennett, F.C. (eds.). The Effectiveness of Early Intervention for At-Risk and Handicapped Children. Orlando, Florida: Academic Press, 1987. See also Provence, S. On the efficacy of early intervention programs. Developmental Pediatrics, 1985, 6, pp. 363-366.

20. Novack, A.H. et al. Children's mental health services in an inner city neighborhood: A 3-Year epidemiological survey. American Journal of Public Health, 1975, 65(2), pp. 133-138.

"Thus the child six summers old
Is not worth much when all is told.
But one must take every care
to see that he is fed good fare.
For he who does not start life well
Will finish badly one can tell...
When October winds do blow,
Then a man his wheat must sow
To feed the other men on earth;
Thus must act a man of worth
Who has arrived at sixty years:
He must sow in young folk's ears
Wisdom all their hearts to fill,
And give them charity if he will."

From a 13th-century poem quoted in Philippe Ariès, Centuries of Childhood: A Social History of Family Life. New York: Vintage Books, 1962, p. 22.

4. PLANNING TO WEAVE LOCAL SERVICES TOGETHER

The overall importance of area planning* to provincial development was identified early on in decentralizing the Ministry,[1] and planning within MCSS reflects its importance. The development of a comprehensive and flexible spectrum of treatment and intervention services depends in large measure on successful area-level planning. At the provincial level, broad policy directions and program emphases are articulated that set the overall strategic directions of the Ministry. These broad directions inform regional and area planning, and are used as benchmarks against which regional and area plans and priorities may be checked. Any interministerial, provincial or even regional strategy will be limited or enabled by the vitality of the local and area-level planning processes in communities.

Effective area planning requires:

- ensuring that new initiatives are a good fit within the context of the local mix of services
- assessing the match of new initiatives with provincial policy and program emphases
- careful examination of program design and objectives with a view to outcome effectiveness.

Discussions follow of area-level planning aimed at the development of an ideal spectrum of treatment and intervention services, and of evaluation design, the first step in planning for new programs.

Area-Level Planning

Tremendous variation exists from area to area in the range, type and responsiveness of local services for children and in the access to and availability of key actors in the delivery of services for disturbed children. To a significant extent, MCSS-approved children's agencies must adjust their

---

* In the context of this discussion on planning, the terms "areas" and "regions" refer to MCSS's 13 areas and four regions. The word "local" is used to refer to any community planning below the area level. This may occur at the level of a county, regional municipality or any other locale with an historical or economic basis for the existence of a "local" community below that of an area. In Northern Ontario, local community may be determined on the basis of population mass or by practical considerations such as reasonable travelling time (e.g., one hour).

planning and programming development to the absence or presence of other services in the area in the task of developing an ideal range of services. In other words, the development of a local spectrum of services must respect the roles played by key actors other than MCSS agencies, and encourage their involvement in planning solutions to local problems. Some areas have very sophisticated planning mechanisms in place to develop a spectrum of local children's services. In some areas, these mechanisms are closely tied to the function of local Children's Services Coordinating and Advisory Groups, while in other areas this responsibility rests solely with the Area Office. In all areas, lead responsibility for ensuring that area planning occurs is ultimately the responsibility of MCSS Area Managers. In some areas, planning has been taken one level finer with the breakdown of areas into local and county planning groups.

Figure 6 on page 55 describes an idealized range of treatment and intervention services organized by responsibility levels within the Ministry. There are of course a number of other essential functions and services for children in a comprehensive local continuum. This paper has outlined those that would seem essential for a developed range of treatment and intervention services. Figure 6 makes clear that most of the main building blocks for service planning are within the area. This is not to de-emphasize regional or provincial planning in any way, but merely to highlight the importance of local and area-level planning.

A number of areas are developing unique and promising area and local planning models and forums for the development of treatment and intervention services and other flexible services. These include Hamilton,[2] Niagara,[3] Barrie,[4] Halton, and Waterloo.[5] The Northern Region is the only region to have published a spectrum of services document that encompasses the treatment and intervention sectors.[6] The Northern Region is currently updating this earlier work, and will be producing a regional companion paper to this document.

In sketching out the spectrum of treatment and intervention services, there is no intention to de-emphasize the overlapping functions in other CFSA services categories. The planning models cited are quite diverse in the way services are integrated. In some cases, integration of services may be achieved by overlapping committees, in others in response to specific service problems. Since the Ministry is currently considering its approach to and

Figure 6

AN IDEAL TREATMENT AND CHILD AND FAMILY INTERVENTION SERVICE SPECTRUM BY SERVICE AND PLANNING LEVEL WITHIN MCSS

LOCAL

- Assessment
- Non-residential services including:
  - child management training, parent groups
  - family support, counselling, therapy
  - individual counselling, therapy
  - social skill training/competency-focussed interventions
  - day treatment/educational programs in care and treatment facilities
  - outreach programming to disturbed children and families
  - non-residential crisis outreach
  - inter-agency professional consultation on all of the above
  - service brokerage for individual families and community groups
  - support of voluntary and client-sector initiatives
- Residential services including:
  - specialized foster care
  - gated and geographically linked short-term crisis stabilization
  - medium- to long-term residential care and treatment
  - educational programs in care and treatment facilities

AREA

- Some specialized residential and non-residential services
- Primary prevention programs for specific "at risk" populations
- Supplementing of existing services for unusual service situations or times of dramatic transition in service or demography
- Multi-disciplinary training and education
- Evaluation services
- Highly specialized services:
  - one-stop multi-disciplinary assessment and consultation
  - direct services (residential and non-residential) to specialized populations (major psychiatric disorder, autism, dual diagnosis; and medical/emotional and behavioural disorders)
  - brokering of complex and unique case situations
  - custom-designed services for complex and unique case situations
  - development of technologically sophisticated research consultation, training and case consultation

REGION

- Child and family advocacy at all levels of service and government planning
- Prevention, including inter-ministerial initiatives, of broad social and biological conditions underlying child and family disturbance
- Facilitating and dissemination of research into causes of major child and family disturbance and effective interventions to reduce child and family disturbance
- Co-ordination of large-scale special projects
- Inter-ministerial differentiation of roles and service functions.

PROVINCE

definition of community, no prescriptive planning model is being offered here. Rather, the intention is to encourage a clear process (which may have many variations) with clear expectations from MCSS Area Managers for the development of a flexible continuum of treatment and intervention services.

This paper referred earlier to Children's Services Past, Present and Future, a consultation document that included a "Status Report 1990" section. In fact, the year 1990 is near at hand. This status report assumed the presence of local co-ordinating committees with funding and planning responsibility for children's services. The committees have not evolved in the fashion anticipated in the early days of the Children's Services Division, and a renewed emphasis on local planning and co-ordination seems warranted.

Developing and strengthening the spirit of partnership between MCSS and local service providers in area-level planning initiatives is an essential and obvious step in developing any new program directions. The Ministry must take leadership to bring the actors together, and ensure some basic staffing resource support to assist the planning. In some areas, this support may be the Children's Services Coordinating and Advisory Group and in some areas it may be MCSS planning staff, while in others agency or Ministry staff may play this role. The key issue here is cultivating the spirit of partnership, building trust and joint responsibility to plan for the solution to local service problems.

In developing an area-level plan, these steps are essential:

1. establish visible and active MCSS leadership
2. convene key sectoral representatives, MCSS and non-MCSS, including Health and Education
3. inventory local resources
4. compare local resources with ideal range of services
5. identify gaps, boundary issues and new service issues
6. consider regional and provincial policy directions
7. develop a plan that identifies priorities
8. identify resources to respond to identified priorities.

In executing these planning steps to fund and develop children's services, the order of priority has been and continues to be to develop local, generic and non-residential services, and build from there to regional, specialized and

residential services. This general approach acknowledges the need to begin with the least intrusive services, closest to clients and families, and build from the local level upwards. Once a skeletal range of treatment and intervention services exists at an area level, the development and funding priority for these services is to build on and add linkages between these services and other services for children. This ground-up approach to service development emphasizes the empowerment of local communities discussed in chapter 2, and will help ensure that services are sensitive to cultural and language needs. Most important, non-residential services are the starting point in line with the non-residential policy emphasis of the Ministry. Non-residential services can begin and stand alone. Residential services do not make sense in the absence of a non-residential intake and discharge, follow-up and support function.

The planning forum helps resolve local service issues by clarifying, through the inventory of resources, who has responsibility for what, where service boundaries are, and so on. Thus it is essential to capture representation from the key sectors not funded by MCSS that may be delivering treatment and intervention services, such as the local hospital or an independent family service organization. Indeed, it may be desirable to involve a range of children's organizations including the local boys' and girls' clubs, the recreational facility, etc. These non-MCSS-funded services can and should be considered part of the local or area resources for disturbed children, and involved in local planning. In this way, some access and advocacy functions can be facilitated, and creative program linkages can be established.

Evaluation of Program Design

Consideration of evaluation design is the first step in planning for a new program, as noted above. Its importance in program development province-wide was identified early on in the process of decentralizing the Ministry.[1] The discussion in chapter 3 indicated a trend in program design away from psychopathologically focussed assessments and interventions towards systemically based interventions, including social and community-based interventions. When planning, however, how does one evaluate the utility and effectiveness of a particular program design? The literature on specialized forms of treatment and intervention with children is enormous and full of methodological ambiguity and uncertainty. The literature on social and

community interventions, including early intervention with at risk and disordered populations, is also growing and intimidating.

Generalizations about the effectiveness of procedures are not highly useful, since outcome studies usually deal with specific techniques used under specific conditions with children of a particular age with specific problems. The effectiveness of specific forms of intervention with children and families is reviewed in a host of annual reviews and edited volumes that appear every year. To attempt any systematic review would be unnecessary and beyond the scope of this document. This paper has already identified recent and comprehensive reviews of primary prevention,[7] early intervention programs[8] and promising social and community intervention models.[9] In relation to social and community intervention and early intervention programs, evaluative approaches have shifted away from a focus on cognitive approaches towards comprehensive interventions employing broad measures of adaptation and social competence (e.g., school performance, staying out of trouble with the law, peer and adult relationships, non-academic skills).

A number of conventional therapeutic programs show some outcome effectiveness.[10] For example, behavioural treatments are effective for phobias and enuresis, and cognitive behavioural approaches are effective for a number of self-control problems (excluding aggressive behaviour). Behavioural treatments are effective in both the increase of appropriate behaviours and the decrease of inappropriate behaviours in children with significant developmental disorders.* Group therapy shows some effectiveness with delinquent adolescents, and some types of family therapy have shown some effective outcomes for conduct-disordered children and those with psychophysiological disorders (e.g., anorexia, bulimia, asthma). Differential use of psychotropic drugs has shown limited effectiveness in children with hyperactivity and attention deficits, depression and enuresis, and also in managing severely disturbed behaviour in some children.

At any rate, concerns with the effectiveness of services and interventions must be continuously addressed from a variety of points of view. These include the immediate and long-range effects on the clients served, client

---

* The use of intrusive behavioural procedures is governed in MCSS facilities by the application of behavioural standards, and will in the future be governed in children's programs as Part VI of the CFSA is proclaimed.

satisfaction and the fit of the program within the continuum of local services and given provincial priorities. In other words, in assessing the design and potential effectiveness of new program initiatives, the following questions might be put:

1. Does the program design allow for an evaluation of client satisfaction?

2. Does the program design allow for an evaluation of outcome effectiveness?

3. Does the program design fit with local priorities in the context of a locally defined continuum of service?

4. Does the program match the provincial policy and program emphases?

Summary and Directions

Planning for children's services reflects the decentralized structure of MCSS across the province. Planning at the area and local levels is highlighted as essential to the development of a flexible continuum of service. An idealized continuum is offered as a model. In the development of a basic range of services, non-residential, generic and local services should be the starting point and residential, regional and specialized services the final point. Program design should be evaluated with a view to client satisfaction, outcome effectiveness, local context and service priorities and provincial policy emphases. The following directions are suggested at the level of local planning.

Direction 6: Enhanced area-level planning is essential to engage communities and services in the development and co-ordination of local services.

Direction 7: Structuring a spectrum of services must be achieved by developing linkages between MCSS and non-MCSS services.

Notes

1. Posner, J. Service Planning at the Area Office Level. Ministry of Community and Social Services, 1982.

2. Association of Agencies for Treatment and Development. Annual Report, 1986. 449 King St. E., Hamilton.

3. Niagara District Health Council and Niagara Children's Services Committee. Child and Adolescent Mental Health Care Services in Niagara. A discussion paper, 1986.

4. Report of the Barrie Area Planning Group on Children's Mental Health. Ministry of Community and Social Services, 1985.

5. The Waterloo Area Service Plan for Children's Mental Health and Child Care. Ministry of Community and Social Services, 1986.

6. Structuring a Service Spectrum. Children's Mental Health Services, Ministry of Community and Social Services Northern Region, 1982.

7. See notes 8,9 and 10 in chapter 2.

8. See note 17 in chapter 3.

9. See notes 10 and 12 in chapter 2.

10. U.S. Congress, Office of Technology Assessment. Children's Mental Health: Problems and Services: A Background Paper (note 2, chapter 2). See in particular the chapters on effectiveness of therapies and services. See also Doherty, G. A Survey of Interventions for Use with Children and Adolescents Who Have Behavioural or Emotional Problems. Prepared for the Northern Region of MCSS by Doherty Social Planning Consultants Ltd., July 1987.

"We may be at an inversion point in history when children and adolescents will once again be recognized as economic assets and therefore be accorded a measure of concern not now evident in our national policies for human resource development."

Nicholas Hobbs and Sally Robinson. "Adolescent development and public policy" in S. Chess and A. Thomas (eds.). Annual Progress in Child Psychiatry and Child Development. New York: Brunner/ Mazel, 1983, p. 312.

5. DEVELOPMENT STRATEGIES

Seven directions were identified in chapters 2, 3 and 4 for the development of treatment and intervention services. The directions are the following.

- Directions at the level of children and their families:

  1. Responsiveness of service to clients and local communities will be the cornerstone of all initiatives.

  2. Continuity of service to clients is to be actively promoted.

- Directions at the level of program design and target populations:

  3. The delivery of primary prevention programs with "at risk" populations will be encouraged.

  4. Detection and early intervention with the youngest identifiable children with serious and chronic behavioural/emotional problems will be encouraged.

  5. Co-ordinated and responsive services for seriously and chronically disturbed children and youth will be encouraged.

- Directions at the level of local planning:

  6. Enhanced area-level planning is essential to engage communities and services in the development and coordination of local services.

  7. Structuring a spectrum of services must be achieved by developing linkages between MCSS and non-MCSS services.

The ordering of the directions does not represent an order of priority, but a description of the levels of application. The directions reflect a three-level focus on clients, programs and populations, and planning. They are offered here with an elaboration of strategies intended to promote discrete and concrete action towards each direction.

As discussed at the outset, the directions may also be applied to the range of children's services. Some of the associated strategies are more distinctly aligned to treatment and intervention services. These strategies are designed to link in a flexible manner certain functions and resources that are stronger in treatment and intervention services with those of other services within CFSA and beyond.

The directions and accompanying strategies are intended to provide a backdrop for the local development of services. They are also intended, as suggested in chapter 1, to strengthen, consolidate, and influence both current and new children's services in a manner that is most effective in meeting the needs of disturbed children and families.

The directions identified will come as no surprise to most people, since many of them are already stated directions and practices in leading children's service organizations. They may represent somewhat unique or new wrinkles on some old faces, however, given the accompanying concrete strategies. The new wrinkles come in the specificity of discrete program emphases, in the promotion of linkage mechanisms between and across CFSA and other treatment and intervention services, and in the focus on the local planning and construction of a continuum of services. What they are <u>not</u> intended to be is "all things to all people". They are intended to represent discrete, effective investment areas for new resources. It is these directions and strategies that are offered for discussion, debate, and feedback to MCSS in the course of consultation.

A fuller discussion of the seven directions and the accompanying strategies follows.

Direction 1: Responsiveness

To the maximum extent possible, the Ministry hopes to see clients and local communities empowered to shape services in accordance with their needs. Services must be developed that build on the competencies of young people and their families and the natural strengths of the local community. This may seem a statement of the obvious, but ensuring responsiveness to clients requires a continuous struggle and specific strategies for service

improvements. Service excellence depends on continuous efforts to develop and maintain an orientation towards the wishes, needs and satisfaction of the human beings who are there to be served. The following strategies are suggested to put clients first.

Strategy 1: Develop services for children and families that are sensitive to their language and culture.

This strategy is already embodied in the CFSA principles cited in chapter 1. This may seem a tall order, however, given the unique concerns of francophone populations in Ontario, the variety of native groups throughout the province and the multicultural fabric of our larger urban communities. There are, however, a variety of creative approaches to this strategy. As is suggested in the discussion of strategy 2, involving client groups through the organization's board and listening to their concerns will naturally aid this process. Personnel recruitment and board membership policies can ensure some cultural and linguistic match of board and staff with the predominant client groups served. Where such arrangements are neither feasible nor warranted by numbers, or recruitment problems exist, sensitivity to culture and language can be achieved by using service-sensitive interpreters from resource groups associated with the particular minority. This can be arranged through a docking mechanism with a language, cultural or ethnic service organization or by a simple purchase of service. Likewise, members of cultural minority groups can be enlisted to educate service providers on an ongoing basis in the values of their particular cultural group and the important meaning ascribed to a professional intervention for the family in that community. Developing a cultural sensitivity is not a one-workshop project, however. A more systematic and continuous sensitization is required.

Remote northern communities offer particular opportunities for the development of culturally sensitive paraprofessionals using indigenous workers. To offset the recruitment problems and logistical problems associated with travelling great distances in areas of low population density, indigenous workers in the North who are culturally and linguistically attuned to clients can be supported by professional consultation in small centres, which can in turn be linked by satellite technology to larger centres.

Strategy 2: Involve clients in key decisions affecting service and as many facets of organizational life as possible.

Because they are consumers of treatment and intervention services, there is a clear need to involve clients, to the extent feasible, in key aspects of and major changes in service activity. The linkage may take such forms as annual or periodic client satisfaction evaluations as well as opportunities for clients to discuss their service experience at board meetings, participate in other board-level activities, volunteer for specific projects, or help design new programs.

Clients can be very articulate in defining what they want from an organization and what they do not like. Treatment and intervention services cannot meet the conflicting needs of all their clients, but they can continuously develop and re-orient their services in line with client preferences.

Strategy 3: Encourage agencies to foster and develop client-initiated efforts to organize client groups, lay-sector networks and voluntary initiatives.

If a client or a set of clients expresses a wish to organize or help with an event, or develop a volunteer program, a parent-support group or a reciprocal relief network for disturbed young people, the activity should be given some manpower and resource support from the funded program where possible. This may be in the form of developmental support without ongoing commitment, or it may involve some limited ongoing resourcing or consultation. This form of blended programming and client-initiated activity requires careful development and role differentiation over time, but gives programs new vitality, enhances the service capacity of the organization, and builds on the strengths of families and communities.

Strategy 4: Evaluate the degree to which programs reflect client needs and responsiveness to clients as first priorities.

At first blush, this statement may seem platitudinous or imply that organizations are insensitive. Of course, children's agencies try to be responsive. Rather, the intention is to help both agencies and areas identify

specific ways to continuously put clients first. A number of questions can be posed about service delivery. For example, do hours of operation adequately reflect client activity and availability? Is there a clear emergency on-call protocol for dealing with crises, and are clients clearly informed about this? Regarding referral and intake, are there clear criteria for determining when and how a client will be served? Where admission decision making is protracted, do clients understand what is being considered; how long it will take to decide; when and how intake decisions will be clearly communicated to them? Is intake set up in a manner that is a responsive first contact with the service? There are a variety of ways to ensure continuous self-examination and maintain the vitality of client-service orientation. These aims can be achieved through the use of small "quality circles" of staff who review case and client interaction with this in mind, and recommend improvements on the total organization back to senior staff. It can be a distinct part of the subject matter of annual meetings, planning forums or service planning. Whatever method is selected, it should constitute a cycle of continuous re-orientation towards client needs to check the natural "drift" in service that occurs in relation to client need.

This client-responsiveness strategy raises additional program-specific questions with respect to area planning. Is there a service in the area that will respond to serious crises with young people 24 hours a day? Is there a rapid-turn-around assessment service in the area? The crisis service need not be residential, but should be gated to a residential or inpatient crisis service if necessary. The assessment service can be linked to the crisis service or a multi-service, one-stop organization. Whatever model is in operation, assessment services must have performance targets for rapid response to assessment requests and rapid communication of assessment data, oral and written.

Another aspect of area and agency planning that merits program- and client-specific reorientation and a fresh focus is the development of outreach and home-based interventions. It is here that client need and professional inclination are at a delicate boundary. How does the organization reconcile the natural inclination of professionals to be "office-bound" with the preference of many clients to be served in the more familiar environment of their home? This is particularly important with very disturbed young people from disorganized and multi-problem families who find it very difficult to

organize scheduled one-hour expeditions to an office. Their needs are often best met through home-based interventions starting with concrete supports in organizing their time, household chores, budgeting, and training in problem solving.[1]

Direction 2: Continuity of Service

Because of Ontario's historical penchant for multiple, small and varied children's agencies, an emphasis on continuity of service is an important part of responsive service. This is not to imply that every child or family should receive services continuously. Where, however, a child and family need to move from one age-based or specialty service to another, there should be mechanisms to promote continuity. Indeed, these mechanisms must reduce barriers to service for children and families in need. The strategies to support this direction are the following.

Strategy 1: Develop gating or docking agreements for programs providing services for specific age groups.

This strategy encourages the identification of "feeder" services for age-discrete service at both the intake and the discharge sides of service. An age-discrete service would be expected to identify those agencies and services that, by memoranda of agreement, have preferred access (gating) to it, and similarly will ensure preferred access for clients leaving that service. This allows for continuous service for the most seriously disturbed young people, forces clarity of mandate in serving specific age groups, and establishes greater accountability. It will also help bridge the gap between predominantly MCSS-funded adolescent services and predominantly MOH-funded adult community mental health services, often referred to as the problem of transitional age youth.

Strategy 2: Develop docking mechanisms to join predominantly single-function services (e.g., residential only or day treatment only) with other specialized and multi-service programs.

This strategy is intended to ensure that the most disturbed young people are gated from service to service in a fashion that makes better "multiple" use of scarce professional resources, and establishes greater accountability. It should

decrease duplication and make maximum use of joint resources. In addition, it should eliminate the notion that every agency should deliver or aspire to deliver a full range of services.

Strategy 3: Develop a case-responsibility focus in services to disturbed children.

This strategy will be assisted by the recent distribution of an MCSS discussion paper entitled Case Responsibility in Ontario: A Resource Document (available through area and regional MCSS offices). In short, an agreed-upon case-responsible individual should be identified in providing service to clients who are involved with multiple services and agencies. This worker will then assume a key role in:

- initiating services and ensuring client consent
- consolidating previous agency contracts and information
- ensuring review of the case and monitoring of the plan of care
- initiating and co-ordinating change in service and the discharge plan
- resolving issues surrounding change in service, and co-ordinating follow-up and the discharge plan.

The case-responsibility designation can provide greater clarity in the co-ordination of complex cases. Where legal guardianship is involved, the specific functions will be negotiated between the guardianship worker and the case-responsible individual, if they are different. This mechanism will identify an accountable individual in the total plan of care who is charged with responsibility for continuity of service and ensuring that communication of case-planning activity is proceeding with the child and family.

These three continuity strategies will help stem the need for "service shopping" on the part of both clients and services. This reduction of the "free market" approach from service to service will be particularly helpful in continuously serving and gating the most seriously disturbed. The developing case-responsibility focus in children's services, with some important exceptions regarding guardianship, parallels the increased emphasis on a case management focus with the adult mentally ill.[2] Probation and child welfare services already maintain a legal "case-responsible" status, although in practice, and by agreement, another worker may assume the case-responsibility functions

without undermining any legal authority or responsibility for child welfare clients or young offenders.

Direction 3: Primary Prevention With "At Risk" Population

The intention here is to emphasize specific discrete primary prevention initiatives. (These services are normally called "community support services" under the CFSA.)

Strategy 1: Target some "at risk" group for primary prevention in each area plan. A minimum target of 2% of the area budget is suggested.

This will require an identification of groups at risk. A nearly complete list of these populations is described in a variety of MCSS and other publications on primary prevention.[3,4]

In the months to come, the OCHS will also publish a paper on children at risk for disorder in Ontario. The particular relationships among social disadvantage, disorder, impairment, and the risk attributable to each disorder will require careful consideration when designing prevention programs. However, a number of effective primary prevention program designs already exist (see notes 8,9,10,11, and 12 in chapter 2) that can be adapted to local areas. The building in of controlled outcome designs and an evaluation budget will be essential in developing comprehensive, effective designs for prevention programs in Ontario.

Strategy 2: Develop a promising primary prevention model, identify one or more target communities, and launch a co-ordinated, large-scale provincial demonstration initiative.

This strategy will involve the co-ordination of resources from other ministries to maximize its potential. It will also require vigorous, systematic comparison of a number of broad indicators and measures of social competence over a four- to ten-year period to assess the cumulative effect of the co-ordinated initiative. Work is under way to identify and develop the most promising, cost-effective and adaptable co-ordinated prevention-initiative model for Ontario.

Direction 4: Detection and Early Intervention

There is currently significant activity in the child care sector within MCSS that promises opportunities for detection and early intervention. The Child Care Branch is planning a significant expansion of services for pre-school children. Early intervention models may involve child care programs, school-based programs and public health-based programs. The strategies supporting this direction are the following.

Strategy 1: Orient assessments with younger children towards assessing risk for disorder causing impairment resulting in the need for long-term treatment and intervention.

This strategy will require the development of weighted predictors for disorder and impairment, based on a variety of social and developmental data. Some of these cumulative risk predictors have been identified.[5,6] The OCHS data on markers for disorder will be in circulation shortly in the second summary paper, and service providers are encouraged to build these predictors into assessments. While these aggregate data are far from having predictive ability in a single case situation they do help to clarify our language of "risk factors". As general as these risk predictors are, they represent an improvement over what we currently use in assessments of children and families. While the skill in developing aggregate estimates of risk is at a rudimentary level, any attempts to improve this skill in assessments are to be encouraged.

Strategy 2: Develop a small number of demonstration programs in selected areas to link professionals who see all of the children (general practitioners, public health nurses, schools) to a specific treatment and intervention service.

This strategy builds on the notion of targetting specific populations of young people for intervention. Because the "universal" systems of public health nurses, schools and medical care touch all children, they can ensure that the most difficult children are identified and referred for early intervention. Use of day care programs may be sufficiently widespread to consider them "universal" in some communities. However, the existence of informal child

care arrangements weakens the potential use of day care for screening and early intervention in any systematic way at this time. Dedicated resources will be required to set up the demonstration programs, and examine the referral patterns and types of childhood problems that emerge. The establishment of effective referral links with schools, public health nurses and networks of G.P.s was perhaps the single direction most frequently suggested by key professional and research informants. A bias towards early intervention with the most seriously disturbed would seem to be the key criterion in this demonstration, since these sources are likely to turn up large numbers of distressed and disturbed children.[7] Professional assessment and consultation back to these referring sources (see direction 7) may help enhance their capacities to continue serving disturbed young children and avoid referring all disturbed children for specialized treatment and intervention.

Strategy 3: Direct existing resources for younger children to enhance parenting skills, relief exchanges and foster care with identified disturbed young children.

This strategy implies support for parents' full potential parenting skill. Further, it encourages measures to relieve pressure on parents that draw on the natural support network as first steps before specialized intervention is considered for younger children. There are a number of developing models for relief exchanges and respite care arrangements between families and foster care providers that hold great promise for maintaining difficult children at home. This strategy should ensure maximum investment in the family and its natural supports before more extensive and expensive professional service is tapped.[8]

Direction 5: Responsive Services for the Seriously and Chronically Disturbed

The term "seriously and chronically disturbed" is used here to refer to those young people with the most persistent and enduring problems and those likely to injure themselves or others. The co-ordination of services for seriously and chronically disturbed young persons requires a balancing of professional resources, access to special inpatient services and a hard-to-serve mechanism. The strategies to support this direction are the following.

Strategy 1: Enable agencies with few professional (psychiatric, psychological, social work, etc.) resources to enter into docking agreements for consultation and back-up by professionals in well-resourced local services.

The reluctance of some community programs to accept seriously disturbed clients stems in part from a genuine concern regarding their capacity to manage these clients effectively. Often the reason is not so much that dramatic gains can be made with professional consultation resourcing, but rather that professional consultation allows a greater sophistication in management, better informed interest in and understanding of complex problems, a greater margin of safety for children and workers, and improved stability in the placement or service situation.

The capacity to develop and mount effective programs for the most disturbed young persons is intimately linked to research programs in this area. Indeed, prevention and treatment programs for conduct disorder require up-to-the moment familiarity with the research literature. Similarly, if Ontario is to reduce the large numbers and persistence of conduct disorder, it will be partly by investing in co-ordinated research and demonstration initiatives (see direction 7, strategy 4).

In terms of service consultation, this may require financial incentives for poorly resourced agencies to purchase services from pivotal well-resourced agencies. Professionally well-resourced agencies should encourage the establishment of outside consultation targets or quotas for their professionals to maximize their value. In this manner, agencies that are well-resourced will begin to have contact with a wide range of other service providers, and be in a position to identify common problems and solutions. In other cases, the financial incentive might be replaced with bartering or exchanging of services. Consultation links between remote programs and well-resourced central programs using the latest available technology are to be encouraged as well.

Strategy 2: Develop gating and docking agreements between hospital inpatient units serving children and adolescents (as well as CFSA secure treatment programs) and community-based case management agencies according to catchment area.

Areas that have hospital inpatient units serving children and adolescents are encouraged to develop agreements with these programs by catchment area. Ideally, these agreements will barter preferred access to short-term beds for continuous follow-up and discharge planning from the time of admission. Whitby Psychiatric Hospital's Cottage 5 Program was developed with these principles in mind, as was Youthdale Crisis Service. Both programs offer models for hospital-community linkage in other areas of the province. The Ministry of Health's New Outlook Program is a community mental health program linked by gating agreements to several hospitals in the service of young adults.

These cross-program agreements require the joint expectations, goodwill and active encouragement of the ministries of Community and Social Services and Health to flourish and develop. In many cases, Education also plays a role in the provision of educational programs in both hospital and community settings.

Strategy 3: Each area identify an individualized "hard-to-serve" mechanism to deal with service problems for young persons with serious, chronic or complex problems.

This mechanism may have a variety of different forms. The essential notion is a body, group of agencies or area-level resource base that can be brought to bear to gain access to or provide services for seriously disturbed young persons who are being refused service. This may be achieved by pooling joint resources, purchasing service, or selectively developing individualized support arrangements. This mechanism can then develop individualized service solutions to complex case problems.

Direction 6: Enhanced Area Planning

The implementation of new directions will pivot on the lively MCSS-community partnership essential to effective area-level planning. The strategies to support this direction are the following.

Strategy 1: Confirm area-level planning expectations and responsibility.

A variety and a range of planning expectations exist in areas within the Ministry, in the service-providing community and between local levels of government. Key informants from different areas expressed great differences in their understanding and expectations of area planning. Important essential features must be confirmed without disrupting or discounting area planning forums currently in place and working well. In some communities, depending on size, the composition of planning groups may involve representatives from all streams of children's services both within the CFSA and beyond MCSS. In other communities, area planning may involve committees of specialized service streams linked through a co-ordinating group of some description.

Essential steps to clarification of expectations include:

1. Establish the Area Office leadership in planning. This may in some cases involve the delegation of some planning functions to the local Children's Service Co-ordinating and Advisory Group (CSCAG). The Area Office needs to lead in this function and clarify expectations regarding planning to CSCAGs or other local planning vehicles. Some staffing resources may be required where none exist.

2. Identify a planning forum with a defined cycle and a critical path. (This may be annual or held every other year, or in some cases include multi-year planning projects.)

3. Begin the development of a spectrum of services by giving priority to local, generic and non-residential services before proceeding through area-level services to regional, specialized and residential services.

4. Ensure key sectoral representation in planning forums, including but not limited to:

   - key treatment and intervention service providers and board members (representative individuals or identified natural leaders)
   - District Health Council/significant health or hospital providers
   - CSCAG (where present)
   - child welfare
   - child development
   - young offenders

- educational sector
- voluntary and lay helping sector
- child advocacy organization
- regional/municipal social service
- prevention advocate
- hard-to-serve advocate.

5. Cultivate a spirit of three-way partnership of trust and responsibility among government, community programs and the consumer sector in developing and implementing area plans. This requires acknowledging the developmental cycles of comfort, confidence and frustration in planning. Furthermore, while planning necessarily produces tension in negotiating priorities, a spirit of partnering and joint responsibility is to be continuously sought after.

6. Produce and disseminate on a regular cycle a priority-based area plan for children's services.

Strategy 2: Establish a contingency between new allocations to areas and regions and area-level planning.

MCSS areas and regions must be held accountable for their allocations through a planning process in the same manner as agencies. Area-level planning is essential for all CFSA service categories. Cohesion in service planning depends on this. The lively interplay between MCSS, the community and service providers must be promoted from a broader perspective, and expanded, if the best solutions to local problems are the objective of planning. Area planning is a complex and arduous task, but can also be an enlightening and constructive activity that builds service solutions to complex problems. The imminent expansion of treatment and intervention services coupled with the historic absence of clear development priorities provides compelling reasons for an articulated area-level planning process.

Direction 7: Structuring a Spectrum of Services

The development of a basic range of treatment and intervention services, as was observed previously, cannot be achieved without involving both services within the CFSA and non-MCSS-funded services. There has always been

significant interdependence between CFSA service streams and other key actors in the community. The evolution of a basic range of treatment and intervention services (see figure 6, chapter 4) should lead naturally to the promotion by service providers of collaborative solutions to common client and community problems. The strategies in support of this direction are the following.

Strategy 1: Use expansion resources to address common problems by promoting solutions that are collaborative and can be evaluated for effectiveness.

The time for public funding of insular service organizations is passing. The development of responsive community service requires active solutions to common problems. Often resource ingredients needed to solve a service problem are located in two or more separate organizations. In areas where parts of a basic range of services are not present, efforts to fill this gap should build on existing local, area and regional services, regardless of funding base. In the remote communities of Ontario, the notion of a complete range of local services will have to be moderated; in some cases service may be provided by local and itinerant generic workers who have access to a range of basic services and professional resources operating in areas with population densities that warrant the full range of service.

All new program proposals for treatment and intervention services should show developed and identified multiple program linkages, role differentiation and reciprocal agreements. This is to ensure that any new program proposals to meet local gaps in services are effectively located in the existing service continuum, and the multiplier effects of collaboration and pooled resources are fully exploited. Expansion of existing resources will no longer be encouraged for stand-alone services. New services will have to identify collaborating organizations and services, and evaluation criteria and methods.

Strategy 2: Enhance links between treatment and intervention services, natural helpers in the community and related professional helpers.

The discussion under direction 1 referred to encouraging the capacity of service providers to enhance service and provide some resource support for

lay, voluntary and client-based initiatives. Non-government-funded child, youth and family programs can be tapped to provide such support. Treatment and intervention professionals can be judiciously deployed to facilitate the necessary linkages to recreational programs, parent groups, boys' and girls' clubs, neighbourhood organizations and so on.

Strategy 3: Each area identify at least one one-stop, rapid assessment service setting explicit performance targets for the provision of an assessment report.

Assessment here refers to a discrete process of systematic information collection and analysis leading to recommendations concerning the need for any form of intervention, and a plan for intervention, if needed. Key informants across the province describe the lack of responsive assessment services as a critical impediment to service delivery, particularly in the capacity of non-MCSS or Health-based services to work with difficult children and their families. General practitioners and pediatricians, who, on the basis of OCHS, see more disturbed young people than any other service sector, find this a particular problem. Provision of a local treatment and intervention assessment service under the CFSA may significantly improve the capacity of both CFSA service providers and other, less specialized helping professionals to deal with disturbed children and families.

This strategy may call for some enhancement of existing resources. However, steps can be taken in the absence of expansion initiatives to identify a one-stop, rapid assessment service, differentiated in role from local health and education assessment services, and to establish a protocol for it. The protocol should establish performance targets that can be communicated easily to referral agents, and specify when the assessment report will be in their hands.

The assessment and plan of care should not duplicate previous assessments, and should be individualized in realistic terms for the client and referral source. In this regard, assessments conducted by professionals engaged in the delivery of a range of services may be more effectively grounded in the realm of possible and available (not just desirable) care than assessments conducted by professionals who are not actively in the business of service delivery. A clear orientation to referral sources outside of the host agency will be

required for this assessment mechanism to have any real multiplier effect. Traditionally, assessments provided by treatment and intervention services have been largely reserved for screening of clients intended for other services within the same organization. This strategy is outward-looking, directed to enabling or assisting other professionals and providers to continue working with their clients.

Strategy 4: Each region develop a mechanism for collaborative research.

The promotion of collaborative research must continue to be a central part of the process of developing a model range of quality treatment and intervention services across Ontario. Regional specification of a lead centre or regional mechanism to build a critical mass of research expertise is necessary. The maintenance or establishment of university links is an essential part of the process. MCSS is in a unique position to draw research interests into the community and away from largely institutionally based interests. The lottery grants for children (1979-1984) and the current round of strategic grants and development grants are good examples of attempts to promote research in community-based settings. Academic links are essential in promoting multi-disciplinary work, developing technical, methodological expertise, maintaining the best methodologies available, and accessing certain key data systems. A regional collaborative research mechanism will also facilitate regional identification of significant local research to fuel the provincial policy development process. This will require the development of an enhanced technological capacity to search through the community using compatible information networks and programs based on state of the art knowledge and information systems. After a developmental period, collaborative mechanisms should enable regional participation in co-ordinated province-wide research initiatives in the field of children's services.

Summary

This chapter opens by reviewing the seven directions for treatment and intervention services identified in previous chapters. It then sketches a series of specific program-based strategies to move in these directions. The directions and strategies are offered as the key elements for discussion, debate and feedback to MCSS.

Notes

1. Halpern, R. Home-based early intervention: Dimensions of current practice. Child Welfare, 1986, LXV(4), pp. 387-398. See also Doherty, G. Basic life skills and Parent Effectiveness Training with the mothers of acting-out adolescents. Journal of Clinical Child Psychology, 1975, Spring, pp. 3-6.

2. Levine, I.S. and Fleming, M. Human Resource Development: Issues in Case Management. Center of Rehabilitation and Manpower Services, University of Maryland, in collaboration with Center for State Human Resource Development and the Community Support and Rehabilitation Branch, National Institute of Mental Health, 1985.

3. Planning and Management Considerations for Prevention in Children's Services. Ministry of Community and Social Services, 1985.

4. Rutter, M. Epidemiological strategies and psychiatric concepts in research on the vulnerable child, in Anthony, E.J. and Koupernik, C. (eds.). Children at Psychiatric Risk, Vol. 3, The Child in His Family. New York: Wiley, 1974. See also notes 8,9,10,11, and 12 in chapter 2.

5. Rae-Grant, N., Thomas, B.H., Offord, D.R. and Boyle, M.H. Risk, protective factors and the prevalence of behavioral and emotional disorders in children and adolescents. Journal of American Academy of Child Psychiatry, 1988, in press.

6. Garmezy, N. (ed.) and Rutter, M. Stress, Coping and Development in Children. Toronto: McGraw-Hill, 1983.

7. Cadman, D., Chambers, L., Feldman, W. and Sackett, D. Assessing the effectiveness of community screening programs. Journal of the American Medical Association, 1984, 251(12), pp. 1580-1585.

8. Appathurai, C., Lowery, G. and Sullivan, T. An expanded role for foster care? Canada's Mental Health, 1986, 34(3), pp. 6-12.

APPENDIX A

KEY INDIVIDUALS AND ORGANIZATIONS CONSULTED

-	MCSS Community Services Policy and Program Staff	
-	Southwest Regional Office, MCSS	
-	Northern Regional Office, MCSS	
-	Central Regional Office, MCSS	
-	Southeast Regional Office, MCSS	
-	Dr. D. Offord	
-	Mr. M. Boyle	Child Epidemiology Unit Chedoke Child and Family Centre Hamilton, Ontario
-	Jonathan Lomas	Department of Epidemiology and Biostatistics McMaster University
-	Dr. S. Bradley	Hospital for Sick Children Department of Psychiatry
-	Dr. R. Geist	"
-	Dr. Goldberg	"
-	Dr. Q. Rae-Grant	"
-	Dr. D. Sakin	"
-	Dr. R. Schachar	"
-	Dr. P. Steinhauer	"
-	Division of Child & Adolescent Psychiatry, Ontario Psychiatric Association	
-	Board and Executive Director, Ontario Association of Children's Mental Health Centres (OACMHC)	
-	Department of Child & Adolescent Psychiatry, University of Toronto	
-	OACMHC Research Committee	
-	Alliance for Children Ontario	
-	Toronto Area Managers and CMHC Program Supervisors, MCSS	
-	Ontario Medical Association Committee on Child Welfare	
-	Barrie Area Children's Mental Health Planning Committee	

Dr. Doug Brown
Executive Director
Children's Assessment & Treatment Centre

George Caldwell
Executive Director
Ontario Association of Children's Aid Societies

Dr. Clive Chamberlain
Executive Director, George Hull Centre
Chief Psychiatrist, Thistletown Regional Centre

Dr. Gillian Doherty
Doherty Social Planning Associates, Ltd.

Lynn Eakin
Executive Director
J.D. Griffin Centre

Doug Finlay
Doug Finlay & Associates

Alice Frey
Executive Director
York Centre for Children, Youth and Families

Bob Fulton
Outside Resources and Foster Care
Children's Aid Society of Metropolitan Toronto

Dr. Ralph Garber
Dean of Social Work
University of Toronto

Dr. Marc Grenier
Ministère des Services Sociaux et de Santé
Province of Quebec

Dr. Gaston Harnois
Douglas Hospital
Verdun, Quebec
Chairman
Mental Health Policy Task Force
Province of Quebec

Dr. Brian Kennedy
C.M. Hincks Treatment Centre

Grant Lowery
Executive Director
Central Toronto Youth Services

Dr. Freda Martin
Executive Director
C.M. Hincks Treatment Centre

Dr. Philip Perry
Executive Director
Woods Homes
Calgary, Alberta

Dr. Alex Richman
Department of Psychiatry
Dalhousie University
Halifax, Nova Scotia

Jim Wakeford
Executive Director
Oolagen Community Services

Dr. Brenda Wattie
Director
Mental Health Branch
Health & Welfare Canada

APPENDIX B

GOALS OF THE ORIGINAL CHILDREN'S SERVICES DIVISION

At the beginning of the decade, the proposed goals for the development of the children's services system in Ontario in the 1980s were:

"1. To define the system in terms of the people it serves and their needs rather than the services provided.

2. To ensure the development and implementation of a comprehensive spectrum of services to meet the needs of the client group.

3. To supplement the family wherever possible rather than providing alternative care.

4. If alternative care is necessary, in specified circumstances, to minimize intervention, disruption and restriction.

5. To establish a cohesive and rational province-wide planning approach.

6. To ensure equality of service among local areas and regions, while permitting variation according to local differences.

7. To decentralize planning and coordination to the local level.

8. To establish a frontline delivery system which, from the client's perspective, is a single, unified system with no arbitrary or artificial decisions or barriers to service.

9. To increase and focus responsibility for each child and family served by children's services.

10. To establish a cohesive, system-wide infrastructure (funding, accounting, information systems) that:

- o supports rather than works against the general goals;
- o eliminates rather than encourages distortions in the consumption of services;
- o works to reduce than facilitate gaps in service."

Source: Children's Services Past, Present and Future. Ministry of Community and Social Services, December 1980.

APPENDIX C

CHILD AND FAMILY SERVICES ACT
SERVICE DEFINITIONS

1. **Child Development Service**

"A service for a child with a developmental or physical handicap, for the family of a child with a developmental or physical handicap, or for the child and the family". Section 3(7), c. 55., S.O., 1984.

"'Developmental handicap' means a condition of mental impairment present or occurring in a person's formative years that is associated with limitations in adaptive behaviour". Section 3(12).

2. **Child Welfare Service**

"'Child welfare service' means:

i) a residential or non residential service, including a prevention service
ii) a service provided under Part III (Child Protection)
iii) a service provided under Part VII (Adoption), or
iv) a service provided under individual or family counselling". Section 3(9).

3. **Young Offenders Service**

"'Young offenders service' means a service provided under Part IV (Young Offenders) or under a program established under that Part". Section 3(29).

4. **Community Support Service**

"'Community support service' means a support service or prevention service provided in the community for children and their families". Section 3(10).

Community support services generally do not target a specific identified child but are aimed at:

- facilitation and/or improvement of social support for populations at risk
- reducing the likelihood of need for ongoing or more intensive MCSS interventions among populations at risk.

Community support services may also include review and advisory bodies.

5. **Child Treatment Service**

"'Child treatment service means a service for a child with a mental or psychiatric disorder, for the family of a child with a mental or psychiatric disorder, or for the child and the family". Section 3(8).

Child treatment services are those services provided to a child and/or the child's family where the child has been diagnosed by a psychiatrist as having a mental or psychiatric disorder, which:

- o are specifically provided to alleviate the mental or psychiatric disorder; and
- o are provided by, or under the direct supervision of, a psychiatrist who retains direct clinical responsibility for the case.

6. **Child and Family Intervention Service**

"A service for a child with a social, emotional and/or behaviour problem, for the family of a child with a social, emotional and/or behavioural problem, or for the child and the family". **(Proposed Amendment)**

Child and family intervention services are those services provided to a child and/or the child's family involving planned interventions based on multi-disciplinary professional approaches designed to alleviate a range of social, emotional and/or behavioural problems experienced by children and their families. They include assessment-applying methods of intervention with individuals, groups and families, re-integration activities and consultation to social systems.

APPENDIX D

KEY POINT HISTORY OF PUBLICLY FUNDED SERVICES FOR DISTURBED CHILDREN IN ONTARIO

Public Welfare Era, 1893-1949

1893 - Children's Protection Act first proclaimed. Orphanages and children's refuges key services.

1914 - Establishment of a "social service clinic" at Toronto General Hospital providing psychiatric consultation to Children's Aid Society, juvenile court and school. (Popularly referred to as "the feeble-minded clinic" owing to preoccupation with the retarded.)

1920s - Toronto Department of Health opens clinic providing psychiatric consultation to schools.

1930s - Province establishes six travelling mental health clinics, each based in a provincial psychiatric hospital. In 1931, 85% of clients were under 21; one-third referred because of suspected or known retardation.

1936 - Borough of York begins mental consultation service.

1937 - Clinic for psychological medicine established at Hospital for Sick Children.

1944 - Mental hygiene consultation service established in Toronto for social workers serving children with emotional disturbance.

1946 - Ontario Government expands its clinic services by appointing consultants to general hospitals in larger urban centres to develop community mental health programs. Children under 16 continue to make up about half of the caseloads of clinic services.

1948 - Federal grant incentives result in establishment of a number of "child guidance clinics". General hospitals begin constructing psychiatric units that provide some services to children.

Residential Treatment Era, 1950-1966

1950 - Orphanages (e.g., Sunnyside in Kingston, Children's Village in Ottawa) begin to get funds from Department of Public Welfare to develop "treatment" programs for "multi-placement" children.

- Growing recognition that traditional medical public health approach had limited application to disturbed children. Beginning of the reluctant but essential marriage of "welfare" and "psychiatric" treatment for disturbed children.

1952 - Establishment of Warrendale by Board of St. Faiths' Lodge.

- Doug Finlay is appointed Director of Protestant Children's Village, incorporating growing therapeutic orientation reflected in works of Redl, Bettelheim, Burmeister, Slavson.

1953 - John Brown is appointed Director of Warrendale, incorporating popular approach of treating children in family-style living environment.

1957 - Ontario Government purchases Hospital for Sick Children's Thistletown campus, then rural and institutional with 64 beds. (Treatment program moved to cottages built on the grounds in 1972.)

1963 - Children's Institutions Act first proclaimed. Facilities classified according to degree of "disturbance" presented by children in them. Deepening "therapeutic" orientation in children's residences.

1966 - Browndale opens "ordinary houses on ordinary streets", small, mixed-age family-style houses. Beginning of true community-based residential treatment.

Proliferation of Services, 1967-1976

1967 - Toronto Mental Health Clinic becomes C.M. Hincks Treatment Centre offering both inpatient and outpatient services.

1967 - Select Committee on Youth notes many children requiring "special treatment" are being sent to training schools, CAS care and charitable institutions owing to short supply of treatment programs.

- White paper by Matthew Dymond on children's facilities for mental and emotional disorders leads to designation of regional centres in Ottawa, Kingston, Toronto, Hamilton, London, Sudbury and Thunder Bay and eventual mandate in legislation for treatment centres for children and adolescents.

1969 - Department of Health sets up children's services branch and hires Dr. Naomi Rae-Grant to develop and co-ordinate services for disturbed children. Conversion from largely user-financed services (often through CAS or probation) to fully funded service, opening doors to increase in non-wards.

- Children's Mental Health Centres Act passed.

1971 - Provision of 100% provincial funding for children's mental health centres. Children's Mental Health Centres Act implemented on April 1, 1971 with jurisdiction over 20 residential facilities (615 beds) and nine non-residential facilities. At the time, children's mental health system also includes 103 beds in special psychiatric hospital units and 162 beds in regional centres.

1972 - Dramatic expansion of residential treatment.

1975 - Services across province to fill in gaps alongside expansion of non-residential service. (Peak in residential capacity of about 1,322 beds in 1974, excluding general hospital units.)

- New policy focus on community-based and non-residential services for least restrictive alternative and support of family systems.

- Repeal of Section 8 of Training Schools Act, which provided for committal of "uncontrollable" children to training school.

Consolidation of Services, 1977-1987

1977 - Consolidation of all services for children with special needs under Children's Services Division, MCSS. Most children's mental health services moved from the Ministry of Health except for some general hospital units and operating responsibility for provincial psychiatric hospital adolescent units.

1977 to 1985 - Development of legislation governing residential standards. Proliferation and refinement of non-residential alternatives including day treatment, home care, parent therapists, satellite clinics, crisis teams, contract workers, etc. Decline in residential treatment both in number of beds and in average length of stay. (In late 1960s average length of residential treatment was 2-4 years; in 1980-81 at Thistletown it was 9.2 months.)

- Increased emphasis on standards of care and children's rights.

- 85 fully funded CMHCs operating in 1985 at a cost of $117 million compared with 20 CMHCs funded in 1971 at a cost of $10 million.

- Federal Young Offenders Act proclaimed 1984.

- Ontario Child Health Study funded by MCSS through McMaster University provides first comprehensive provincial epidemiological data base for psychiatric disturbances in children and adolescents.

1985 - Passage of omnibus Child and Family Services Act consolidating, updating and replacing numerous pieces of legislation including the Children's Mental Health Services Act. With service planning and flexible funding mechanisms of CFSA, children's mental health becomes a program and function designation rather than an agency-based designation.

1987 - All but 14 CMHCs are delisted from schedules under the Mental Health Act and consolidated under the CFSA as approved agencies.

Note

The Ministry is indebted to Gillian Doherty for her original historical summary of services in Three Decades of Change: The Evolution of Residential Care and Community Alternatives in Children's Services. Ministry of Community and Social Services, 1983. Thanks are also due to Doug Finlay for his helpful comments on this cryptic history of services. For the many significant individuals, organizations and agencies not mentioned in this synopsis, no slight was intended. This summary merely offers one snapshot of history that will never quite reflect the collective efforts and commitments of the many dedicated people who have helped to bring services for disturbed children in Ontario to the forefront. In relation to the eras described, "proliferation" may imply some purposelessness, "consolidation" some precise rationale. Neither term is quite accurate historically, but it is hoped that they transmit some flavour of the direction of activities in these periods.

APPENDIX E

THE MINISTRY OF HEALTH'S ROLE IN TREATMENT SERVICES FOR DISTURBED CHILDREN

In 1977, the majority of responsibility for children's mental health services was transferred from the Ministry of Health to the Ministry of Community and Social Services. Health retained some responsibility, however, and works collaboratively with the Ministry of Community and Social Services. The status of children's mental health services with which Health is involved is outlined below.

Inpatient Child Treatment Services in Public Hospitals Funded Exclusively by Health

London	-	Victoria Hospital, Children's Hospital of Western Ontario
Ottawa	-	Children's Hospital of Eastern Ontario
Toronto	-	Hospital for Sick Children
	-	Sunnybrook Medical Centre

Adolescent Programs in Provincial Psychiatric Hospitals

Three provincial psychiatric hospitals operate adolescent programs but receive funds for salaries from the Ministry of Community and Social Services through a purchase-of-service agreement:

London Psychiatric Hospital	-	residential program
Whitby Psychiatric Hospital	-	residential program
St. Thomas Psychiatric Hospital	-	outpatient services only

General Mental Health Services

General and psychiatric hospitals may provide services to children with mental health problems through emergency departments, adult psychiatric units and family services programs.

Community-Based Children's Mental Health Programs

The New Outlook Program was developed in Metropolitan Toronto to bridge the gap between children's and adult's mental health services for young

people aged 16 to 24. The program has been funded by the Ministry of Health since December 1984. It provides individual and day treatment services to mentally disturbed young people, assisting them with their education, preparation for independent living and work, and adjustment to the pressures of urban life.

Youth Clinical Services

Youth Clinical Services in Downsview is a multi-service centre that provides counselling and medical and educational services to adolescents, young adults and their families. Attention is paid to clients with severe psychiatric and psychosocial problems.

Young Adult Psychiatric Day Program

The Young Adult Psychiatric Day Program began operation in Kitchener in early 1987. This program will treat clients in the 16-20 age range with affective disorders who would otherwise be hospitalized.

Child and Family Mental Health Services Funded by Health and MCSS

Four public hospitals receive funding from both ministries, from Health for adult services and from MCSS for children's services:

Chedoke-McMaster Hospitals
Royal Ottawa Hospital
Sudbury Algoma Hospital
Windsor Western Hospital

In addition, both ministries fund four community-based programs; Health funds adult services and MCSS children's services:

North of Superior Community Mental Health Program
Lanark Community Mental Health Program
Sudbury-Algoma Community Mental Health Clinics
Guelph Community Mental Health Clinic

These programs provide a broad range of mental health services to children and adults.

Child and Family Studies Centre

This centre is located at the Clarke Institute of Psychiatry, and focusses its activities on a program to assess and treat children with communication and psychiatric disorders; a program to treat the psychological problems of immigrant children; studies of the biomedical concerns arising from childhood psychiatric disorders; and a program for dysfunctional families caused by tensions arising from separation, divorce, remarriage, and relocation.

Outpatient Child and Family Clinics

Twenty general hospitals continue to receive Ministry of Health funding earmarked for the operation of outpatient child and adolescent clinics that were in place at the time of the transfer of services from Health to MCSS in 1977.

Inter-Ministry Committee on Children's Mental Health Services

This joint Health-Ministry of Community and Social Services committee was established in April 1983 to facilitate co-operation by and co-ordination of services for children and adolescents with mental health problems.

APPENDIX F

SERVICES PROVIDED BY THE MINISTRY OF EDUCATION

FOR CHILDREN WITH SPECIAL NEEDS AND EXCEPTIONALITIES

Table I

SERVICES PROVIDED BY SCHOOL BOARDS FOR CHILDREN WITH BEHAVIOURAL EXCEPTIONALITIES

Area of Exceptionality	Elementary Schools		Secondary Schools	
	Self-Contained	Resource Withdrawal	Self-Contained	Resource Withdrawal
Behavioural exceptionalities*				
Socially maladjusted, Emotionally disturbed	2,901	2,315	545	2,343

Total Number of Pupils with Behavioural Exceptionalities	8,104
Number of schools with special education programs (includes all types of exceptionalities)	4,476
Number of exceptional pupils (all types of exceptionalities) receiving special education programs	136,356
Total enrolment in the school system	1,796,244

---

* Does not include enrolments in care and treatment centres.

Source: Ministry of Education September 1986 Board Report.

Table II

NUMBERS OF TEACHERS IN CARE AND TREATMENT CENTRES

	Junior Kindergarten to Gr. 8 JK-8/M-8				High Schools 9-13				Total			
	English	(%)	French	(%)	English	(%)	French	(%)	English	(%)	French	(%)
Psychiatric Facilities & Treatment Centres	290.3	(93.1)	21.5	(6.9)	93.8	(89.7)	10.8	(10.3)	384.1	92.20	32.3	(7.8)
Developmental Centres	30.5	(95.3)	1.5	(4.7)	3.0	(75.0)	1.0	(25.0)	33.5	(93.1)	2.5	(6.9)
Children's Residences	109.2	(99.1)	1.0	(0.9)	43.2	(100.0)	0.0	(0.0)	152.4	(99.3)	1.0	(0.7)
Homes for Retarded Persons & Homes for Special Care	32.2	(100.0)	0.0	0.0	0.0	(0.0)	0.0	(0.0)	32.2	(100.0)	0.0	(0.0)
Observation & Detention Homes	28.2	(99.3)	0.2	(0.7)	61.7	(96.6)	2.2	(3.4)	89.9	(97.4)	2.4	(2.6)
Hospital for Sick Children Bloorview Child. Hospital Child. Hosp. of Eastern Ont. Child. Hosp. of Western Ont. Lyndhurst Lodge	30.3	(85.7)	5.0	(14.3)	7.0	(73.7)	2.5	(26.3)	37.0	(83.1)	7.5	(16.9)
Other	17.1	(79.0)	4.7	(21.0)	22.9	(100.0)	0.0	(0.0)	40.6	(89.6)	4.7	(10.4)
Total	538.1	(94.1)	33.9	(5.9)	231.6	(93.3)	16.5	(6.7)	769.7	(93.9)	50.4	(6.1)

Source: Ministry of Education September 1986 Board Report, Provincial Summary.

APPENDIX G

MISCELLANEOUS BACKGROUND DATA

Table III

SELECTED CHILDREN'S SERVICES BY PROVINCE, REGION AND AREA
1986/87 ACTUAL $ EXPENDITURE

	CMHCs	Children's and Youth Institutions	Kinark Child and Family Services	Direct Operating Expenses[1]	Total	Per Child Expenditure	% of Average
Ontario Total	111,530,175	15,325,031	14,280,600	15,792,104	156,928,900[2]	67.53	100.0
Central	43,423,527	7,456,811	7,346,300	6,027,264	64,253,902[3]	71.87	106.43
North	19,166,305	194,622	3,038,800	--	22,399,727	90.81	134.47
Southwest	27,209,950	5,546,360	--	9,764,836	42,521,146	59.00	87.37
Southeast	21,566,520	2,128,238	3,895,500	--	27,590,258	59.67	88.36
Mississauga	4,962,501	466,879	--	--	5,429,380	21.31	32.11
Toronto	33,802,569	6,168,068	--	4,214,217	44,184,854	91.37	137.67
Barrie	4,655,569	821,864	4,993,800	--	10,471,233	67.29	101.39
Thunder Bay	5,437,170	194,622	3,038,800	--	8,670,592	125.47	189.05
Sudbury	8,087,740	--	--	--	8,087,740	84.38	127.14
North Bay	5,538,185	--	--	--	5,538,185	67.78	102.12
London	5,289,316	1,470,783	--	9,764,836	16,524,935	89.52	134.88
Hamilton	9,343,488	1,737,426	--	--	11,080,914	49.40	74.43
Windsor	10,324,808	708,400	--	--	11,033,208	74.42	112.13
Waterloo	2,708,789	1,173,299	--	--	3,822,088	23.74	35.77
Peterborough	2,563,248	730,000	3,895,500	1,813,047	9,001,795	59.86	90.19
Ottawa	12,817,061	1,356,238	--	--	14,173,299	68.32	102.94
Kingston	6,108,928	42,000	--	--	6,150,928	58.82	88.62

Notes

1. Includes portions of Children's Psychiatric Research Institute (CPRI) and Thistletown, and ledger transfers related to provincial psychiatric hospital child and adolescent units. Portions of these data are depicted in figure 2, chapter 2.
2. Provincial total includes a greater actual expenditure than regional total due to corporate activity.
3. Regional total includes a greater actual expenditure than area total due to regional activity.

Table IV

**SELECTED CHILDREN'S SERVICE CATEGORIES*
BY PROVINCE AND REGION
MCSS 1987/88 $ ALLOTMENTS****

Transfer Payments	**Central**	**North**	**Southwest**	**Southeast**	**Ontario**
Development Services Schedule II Facilities	-	-	4,216.0	1,509.9	5,725.9
Children's Accommodation	9,442.6	3,641.5	9,524.1	4,905.0	29,513.2
Community Support	9,024.4	6,192.7	6,579.8	7,360.6	29,157.5
Subtotal:	18,467.0	9,834.2	20,319.9	13,775.5	62,396.6**
Per Child Expenditure	20.66	39.87	28.20	29.79	26.85
Community Support	4,975.5	1,765.2	2,821.3	681.3	10,243.3
Per Child Expenditure	5.59	7.16	3.91	1.47	4.41
Child Welfare	73,466.3	35,790.0	45,951.4	40,343.2	195,550.9
Per Child Expenditure	82.18	145.10	63.76	87.25	84.15
Child and Family Intervention	62,146.0	16,190.4	27,996.3	22,155.9	128,488.6
Per Child Expenditure	69.52	65.64	38.85	47.91	55.29
Child Treatment	3,750.1	1,824.2	2,832.3	1,380.8	9,787.4
Per Child Expenditure	4.19	7.40	3.93	2.99	4.21
Young Offenders Act (YOA)***	14,996.5	6,602.5	10,803.9	6,709.3	39,112.2
Per Child Expenditure	16.78	26.77	14.99	14.51	16.83
Direct Operating Expenses					
Child Treatment and Child and Family Intervention					
Adolescent Units/ Psychiatric Hospitals	-	-	2,286.9	1,449.7	3,736.6
Thistletown	9,142.3	-	-	-	9,142.3
CPRI	-	-	7,972.1	-	7,972.1
Subtotal:	9,142.3	-	10,259.0	1,449.7	20,851.0
Per Child Expenditure	10.23	-	14.24	3.14	8.90

Other CFSA Services DOE					
Thistletown	6,925.0	-	-	-	6,925.0
CPRI	-	-	7,763.7	-	7,763.7
Subtotal:	6,925.0	-	7,763.7	-	14,688.7
Per Child Expenditure	7.75	-	10.78	-	6.32
Subtotal for Child Treatment and Child and Family Intervention (Transfer Payment and Direct Operating Expenses)	75,103.8	18,014.6	41,087.6	24,986.4	162,436.8
Per Child Expenditure	83.94	73.04	57.02	54.04	68.40
Total (Transfer Payment and Direct Operating Expenses)	193,868.7	22,006.5	128,747.8	86,495.7	481,118.7
Per Child Expenditure (All CFSA Categories)	216.90	291.92	178.65	187.05	207.05

* Figures are based on second quarter allotments to regions in 1987/88. Portions of these data are depicted in figure 3, chapter 2.

** Allotment figures are in thousands of dollars.

*** Figures do not include YOA direct operating expenses or child care. YOA transfer payment figures are included.

Table V

UTILIZATION OF RESIDENTIAL AND NON-RESIDENTIAL SERVICES BY AREA, REGION, PROVINCE, 1985-86

	Total Number of Admissions/Re-Admissions					No. of Individual Children Served in Ontario
Residential Services	**Central**	**North**	**Southwest**	**Southeast**	**Ontario**	
Children's Aid Societies	6,451	4,564	6,337	3,941	21,293	16,560
Secure Custody	68	672	234	444	1,418	642
Contract Group Homes	42	30	154	11	237	95
Independent Group Homes	936	402	893	890	3,121	1,755
Extended Family Homes	49	3	313	84	449	294
Detention Homes	1,944	607	1,253	628	4,432	1,508
Children's Mental Health Centres (CMHCs)	921	300	647	480	2,348	1,535
Maternity Homes	176	16	105	50	347	311
Children's Institutions (CYIs)	541	191	1,217	89	2,038	1,383
MR Community Accommodation	50	-	224	3	277	116
MR Facilities	395	72	560	57	1,084	744
Foster Homes	35	49	6	66	156	91
Open Custody Foster Homes	90	64	16	29	199	53
Adolescent Units/Psychiatric Hospitals	46	-	103	41	190	122*
Adult Units/Psychiatric Hospitals	16	43	45	21	125	80*
Adolescent Units/General Hospitals	115	28	108	61	312	200*
Adult Units/General Hospitals	444	85	399	198	1,126	722*
Total	12,319	7,126	12,614	7,093	39,152	26,211
% of Child Population Served	**1.38**	**2.89**	**1.75**	**1.54**	**1.69**	**1.13**
Non-Residential Services						
Children's Mental Health Centres						
Total	12,701	5,369	10,786	5,678	34,534	
% of Child Population Served	**1.42**	**2.18**	**1.50**	**1.23**	**1.49**	

* Estimate.

Notes to Table V

1. Residential facility definitions:

   a. Children's Aid Societies: Any residential services supervised by a Children's Aid Society. These would include foster homes, treatment homes and assessment homes.

   b. Secure Custody: A place of secure containment or restraint for young persons who meet the criteria for secure custody specified in The Young Offenders Act.

   c. Contract Group Homes: Residential facilities for young persons who have been sentenced under The Young Offenders Act. These facilities provide care for more young offenders clients than foster homes do.

   d. Independent Group Homes: A transitional care programs stressing skills and self-dependence. Any young person can be referred from other services, e.g., CAS, CMHC, YOA.

   e. Extended Family Homes: Homes that are operated by a parent agency to provide care for children in a foster-home-type setting. The capacity of these homes is usually from two to four children.

   f. Detention Homes: Residential facilities for young persons who have been charged under The Young Offenders Act, and have an order to reside while waiting for trial.

   g. Children's Mental Health Centres: Residential treatment and child and family intervention facilities for children with social, emotional, behavioural and psychiatric problems, formerly listed facilities under the Mental Health Act.

   h. Maternity Homes: Residential care facilities that provide prenatal and postnatal counselling and support for pregnant youths and teen single parents and their children.

   i. Children's and Youth Institutions: Residential programs that provide support for children and youths with social, emotional and behavioural problems.

   j. MR Community Accommodation: A small residential facility for children with developmental handicaps.

   k. MR Facilities: Institutional residential facilities for developmentally handicapped children.

   l. Foster Homes: Private family homes where residential care is provided for no more than four children (unrelated to the foster parents) under the supervision of probation officers.

m. Open Custody Foster Homes: Foster homes licensed to provide care for youths sentenced under The Young Offenders Act. Supervision is conducted by Probation Services. Some open-custody foster homes accommodate other youths under the supervision of a probation officer.

2. Data were collected by the area in which the facility was located, except for the hospital data that were collected by the child's MCSS area of residence and assembled by that area.

3. Statistics from open custody foster homes, secure custody, detention homes, and contract group homes have a higher estimate of error (underestimation error) than other facilities due to difficulty matching information on YOA clients on Child Advocacy Information System discharge forms.

4. The accuracy of statistics from MR facilities and MR community accommodation is affected by problems in the structure for reporting to the centralized file due to long-term stay of clients (underestimation error).

5. Statistics for the total number of children served include significant readmissions to the same facility type (49%) and cross-over admissions to another facility type (16.2%). About half of these cross-over admissions were re-admitted to the second facility type. The vast majority of these various types of re-admissions originate and occur in child welfare and to a lesser extent young offender services.

6. Other publicly-funded, non-residential services not included are those provided by Children's Aid Societies, Probation Services, Employment Initiatives, and the hospital outpatient units referred to in Appendix D.

7. While there are significant errors noted in reporting utilization, the figures expressed do give a picture of scale of utilization of these services.

Table VI

CHILDREN'S MENTAL HEALTH SERVICE REFERRAL TRENDS

Referral Service	Admissions				Re-Admissions				Total			
	82/83	83/84	84/85	85/86	82/83	83/84	84/85	85/86	82/83	83/84	84/85	85/86
0 Unknown	120	116	155	166	31	36	26	40	151	152	181	206
1. Parent	4,843	5,100	5,452	6,023	1,289	1,358	1,386	1,488	6,132	6,458	6,838	7,511
2. Self	344	361	855	785	102	95	153	136	446	456	1,008	921
3. Psychiatrist	466	366	331	307	52	46	41	37	518	412	372	344
4. Other Clinical	3,866	3,189	3,195	2,753	379	278	278	252	4,245	3,467	3,473	3,005
5. Other CMHC	1,190	1,163	1,106	1,099	116	153	158	191	1,306	1,316	1,264	1,210
6. MR Facility	81	66	62	46	15	18	11	4	96	84	73	50
7. General Hospital	690	724	754	780	59	57	61	71	749	781	815	851
8. CAS	2,131	2,450	2,344	2,299	338	388	424	420	2,469	2,838	2,768	2,719
9. Educational Agency	1,254	1,079	761	752	242	206	148	130	1,496	1,285	912	882
10. Court Facility	1,254	1,079	761	752	242	206	148	130	1,496	1,285	912	882
11. Public Health Nurse	622	591	487	455	48	38	26	27	670	629	513	482
12. Other	1,683	1,674	1,806	1,922	173	143	166	172	1,856	1,817	1,972	2,094
Total	**21,982**	**21,257**	**21,392**	**21,153**	**3,344**	**3,274**	**3,356**	**3,495**	**25,326**	**24,531**	**24,748**	24,646

Source: Children's Mental Health Services Information System.

APPENDIX H

SAMPLE MEMORANDA

OF AGREEMENT

MEMORANDUM OF AGREEMENT

Between

NEW OUTLOOK, CENTRAL TORONTO YOUTH SERVICES

and

QUEEN STREET MENTAL HEALTH CENTRE

---

1. New Outlook will accept clients referred by Queen Street Mental Health Centre who meet the program criteria, following team discussion and as space permits.

2. New Outlook will provide case management and/or day treatment services until the clients' 25th year, or earlier, if appropriate and advisable.

3. New Outlook will assist the referring agent in linking the client to more age and/or need appropriate services prior to discharge from the program with the understanding that the responsibility lies with the referring agent.

4. Queen Street Mental Health Centre is responsible for providing case coordination services to clients referred to New Outlook, including:
   - medical/therapeutic services
   - crisis assessment and intervention
   - when necessary, arranging readmission

5. Queen Street Mental Health Centre agrees to notify and involve New Outlook staff in admission and discharge planning for their clients for purposes of continuity of care.

6. It is agreed that this proposal will remain in effect unless revoked in writing by either New Outlook or Queen Street Mental Health Centre.

Signed: _____

Position: Executive Director — New Outlook

Date: July 2/85

Signed: _____

Position: Psychiatrist-in-Chief and Clinical Director — Queen Street Mental Health Centre

Date: June 20, 1985

The George Hull Centre
for Children and Families

LETTER OF UNDERSTANDING/AGREEMENT BETWEEN CITY OF ETOBICOKE HEALTH AND THE GEORGE HULL CENTRE

RE: BEST PROGRAM, June, 1986 - June, 1988

PARTIES: Clive Chamberlain
Executive Director,
The George Hull Centre for Children and Families.

(Ms.) Elizabeth Ridgely,
Clinical Director,
The George Hull Centre for Children and Families.

(Ms.) Gladys Rothman,
Coordinator, Prevention Services (BEST Program)
The George Hull Centre for Children and Families

and

(Mrs.) Mirjana B. Stijovic, R.N., MPH.,
Director, Nursing Division
City of Etobicoke,
Health Department.

A.M. Egbert, M.D., D.P.H.,
Medical Officer of Health
City of Etobicoke,
Health Department.

OBJECTIVES To outline the commitments and responsibilities of the two parties associated with service delivery, and data collection in the BEST (Baby Early Stimulation Team) Program.

RECEIVED
JUN 25 1986
CITY OF ETOBICOKE
HEALTH DEPARTMENT

600 The East Mall, 3rd Floor, Etobicoke, Ontario, Canada, M9B 4B1. Tel (416) 622-8833

TASKS AND PROCEDURES

The George Hull Centre

The George Hull Centre agrees:

1. To provide training courses to the City of Etobicoke, Public Health Nursing personnel in the curriculum, testing procedures and techniques to be used in the BEST Program. These training courses will be provided once every six months to a group of Etobicoke Public Health Nurses who have not previously received the training.

2. To provide verbal feedback to the front-line and supervisory nursing staff associated with the BEST Program every six months, regarding any changes in infants' level of functioning based on Gesell Test scores.

   Information will be provided in a format that maintains the anonymity of the individual families enrolled in the program.

3. To provide verbal feedback to the nursing staff participating in the BEST Program about their program-related skills once every three months.

4. To provide assessment and informal information regarding child-rearing and parental goals to families participating in the BEST Program, upon identification of such need by Etobicoke Public Health nursing staff and with the agreement and judgement of The George Hull Centre.

TASKS AND PROCEDURES (continued)

The George Hull Centre (continued)

5. To seek the agreement of Etobicoke Health Department Nursing Division, when video tapes made during BEST Program home visits are to be used for purposes other than research, training, education, community development or prevention of social, emotional and cognitive delays or abnormalities in infant development.
6. Record descriptive data compiled at time of intake.
7. At the end of the two year period, Program Coordinator will provide a written summary of descriptive data: number of cases, length of time in program, referral sources, reported changes in Gesell scores and written summary of feedback from nurses of their perceptions of the BEST Program.

Etobicoke Health Department Nursing Division

The Etobicoke Health Department, Nursing Division agrees to:

1. Assign a minimum of 10 public health nurses to deliver the BEST Program to "at risk" families identified by community referral sources, and who meet the BEST criteria, and who volunteer as participants during the period of June, 1986 to June, 1988.
2. Take the BEST Program Coordinator, or designated assistant, along during the first home visit to BEST Program participant families.

Etobicoke Health Department Nursing Division (continued)

3. Perform home visits once per month for each case.
4. Perform and score the Gesell Test once every month for each case until the child is one year old, after which time the Gesell Test will be scored once every three months.
5. Model the appropriate activities each month for the mother. These activities are outlined in the manual used by BEST Program and will be a function of the child's score on the Gesell Test.
6. Discuss identified problem areas with the mother (based on child's Gesell score) and report these problem areas by telephone to the BEST Program Coordinator within one week of the visit.
7. Communicate by telephone the monthly Gesell Test scores performed by the child, to the BEST Program Coordinator, and agree also to keep a written record of each Gesell Test score within the case file.
8. Attend team meetings once per month.
9. Agree to allow nursing staff to be video taped when BEST Program Coordinator determines that it would be necessary for research, training, education, community development or prevention of social, emotional and cognitive delays or abnormalities in infant development.

TASKS AND PROCEDURES (continued)

Etobicoke Health Department Nursing Division (continued)

10. Agree to periodic checks on program-related skills of nursing staff by Program Coordinator or her designated assistant.
11. Maintain program-related client records and confidentiality of same.
12. Provide designated nursing supervisor to be attached to BEST Program.

(This agreement will be renewable in June 1988 for an additional period.)

Clive Chamberlain
Executive Director,
The George Hull Centre for
Children and Families

A.M. Egbert, M.D., D.P.H.,
Medical Officer of Health
City of Etobicoke,
Health Department.

Ms. Elizabeth Ridgely
Clinical Director
The George Hull Centre
for Children and Families

Mrs. M. Stijovic, R.N., MPH.,
Director of Nursing,
City of Etobicoke,
Health Department.

Ms. Gladys Rothman
Coordinator,
Prevention Services (BEST)
The George Hull Centre
for Children and Families.

RECEIVED
JUN 25 1986
CITY OF ETOBICOKE
HEALTH DEPARTMENT

May, 1986.

APPENDIX I

RANKING OF ONTARIO DIVISIONS ON SOCIAL INDICATORS

From a report by Doherty Social Planning Consultants Ltd.: A comparison of the Official Ontario Divisions in regard to the extent to which they have children and families at risk of requiring a CFSA service other than a Child Development Service, 1987.

The ranking was made using a CFSA-based formula. Higher numbers are associated with higher likelihood of requiring service.

RANKS AND TOTAL SCORES OF ALL OFFICIAL ONTARIO DIVISIONS USING CFSA-BASED SOCIAL INDICATORS

Region	Division	Rank	Score
Central	Metropolitan Toronto	29	149
	Dufferin	2	123
	Halton	6	126
	Peel	6	126
	Simcoe	3	123
	York	3	123
Southeast	Durham	6	126
	Frontenac	29	149
	Haliburton	23	145
	Hastings	19	136
	Lanark	15	131
	Lennox & Addington	6	126
	Leeds & Grenville	1	120
	Northumberland	13	127
	Ottawa-Carleton	20	140
	Peterborough	20	140
	Prescott & Russell	17	134
	Prince Edward	6	126
	Renfrew	16	132
	Stormont-Dundas & Glengarry	22	143
	Victoria	3	123
Southwest	Brant	23	145
	Elgin	14	128
	Essex	32	154
	Grey & Bruce	6	126
	Haldimand-Norfolk	17	134
	Hamilton-Wentworth	31	152
	Huron	6	126
	Kent	33	157
	Lambton	25	146
	Middlesex	34	158
	Niagara	37	163
	Oxford	25	146
	Perth	25	146
	Waterloo	34	158
	Wellington	25	146
North	Algoma	36	162
	Cochrane	40	191
	Kenora	40	191
	Manitoulin	46	200
	Muskoka	38	180
	Nipissing	44	195
	Parry Sound	43	194
	Rainy River	39	188
	Sudbury Dist.& reg. munic.	47	206
	Thunder Bay	42	192
	Timiskaming	45	197

CHILD AND FAMILY SERVICES ACT FORMULA

Factor	Indicator	Yr./Mo.	Data Source
1. Premature birth rate	Rate live births under 2,500 gr.	1985	Ministry of Health
2. Rate of births to teenage mother	Live births to mothers under 20 x 100/live births	1985	Ministry of Health
3. Parental unemployment	UIC x 100/labour force 1981	1986/12	Ministry of Treasury & Economics/Stats. Can.-Census 93 966 Table 1
4. Low-income families	Low-income families x 100/total families	1981	Stats. Can.-Census E576 Table 1
5. Family on welfare	Number Family Benefits Assistance children under 16	1987/01	Ministry of Com. & Social Services
6. Single-parent family rate	Lone parents with children under 18/total families with children under 18	1981	Stats. Can.-Census Microfiche SDF 81 A13
7. Subsidized housing	Families in subsidized housing/1981 families with children under 18	1986	Social Housing Inventory/Stats. Can.-Census Microfiche SDF 81 A13
8. Mother's low education	Females over 15 years with less than grade 9 x 100/total females over 15 years	1981	Stats. Can.-Census 93 930 Table II
9. Overcrowded housing	Average number persons/room	1981	Stats. Can.-Census E576 Table 1
10. Urban residence	Pop. in towns over 25,000 inhabitants/total population	1981	Stats. Can.-Census